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Rhode Island Medical Journal

Vol. XX, 1937

Published for the Rhode Island Medical Society
Under Direction of the Committee on Publication
106 Francis Street, Providence

THE ROGER WILLIAMS PRESS
E. A. JOHNSON COMPANY
PROVIDENCE, RHODE ISLAND

NEW YORK ACADEMY
OF MEDICINE
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THE RHODE ISLAND MEDICAL JOURNAL

Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society

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(1) 1936 J. Nutrition 11, 55.

(2) 1936 J. Home Econ. 28, 18.
1925 Ibid, 17, 265

(3) 1935 J. Home Econ. 27, 376
(4) 1917 Amer. J. Dis. Chila, 14, 34

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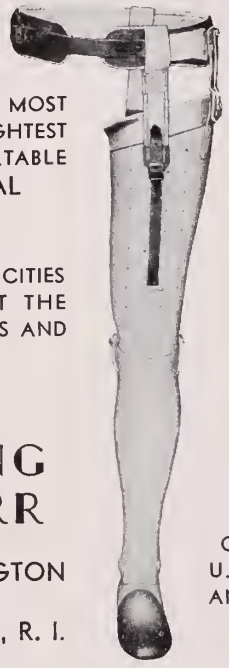
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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

VOLUME XX
NUMBER 1
Whole No. 328
PROVIDENCE, R. I., JANUARY, 1937
PER YEAR $2.00
SINGLE COPY 25 CENTS

PROGRESS IN PRIVATE PRACTICE. IS SOCIALIZATION OF MEDICINE NEEDED?

ALEX. M. BURGESS, M.D.
454 ANGELL STREET, PROVIDENCE, R. I.

To one who himself earnestly believes in the general elimination of the profit motive and the equitable distribution among all citizens of the advantages of a rich civilization, the proposal to begin by a destruction of the private practice of medicine arouses a mixture of feelings among which not the least is apprehension. Conscious, as is every physician, of the social inadequacy of certain phases of the present situation and of the occasional occurrence of instances of flagrant injustice to individuals, one is also conscious of the great mass of conscientious, self-sacrificing and on the whole poorly paid endeavor on the part of a body of men in whom the profit motive is actually as well as traditionally of secondary importance. The question at once arises—is it wise to begin socialization where perhaps the need is least and where a failure to achieve an adequate adjustment will act as a tremendous damper on all enthusiasm for further attempts at much needed social reform in other fields?

This leads to a direct attempt to appraise the adequacy of the present system of private practice. Constant criticism is being levelled at the profession by intelligent laymen—criticism that is often well deserved and not to be disregarded. Such unfavorable comment is of the greatest practical value and will add to the efforts of the best minds in the profession that effective stimulus from without which will force the conclusion that if the profession will not itself clean house it may be compelled to do so by public action. This would mean the loss to the profession of its much cherished liberty in the direction of its own affairs.

The recent article by Professor Laski entitled "The Decline of the Professions" (*Harper's*, November, 1935) is an excellent example of this type of constructive criticism. The ability of the physician to contradict on the basis of his own experience this or that individual statement in such an article is not sufficient ground for discounting the whole, especially as some of the arraignment must be admitted by all. But is "the individualistic organization" of the profession "fatal to the fulfillment of its function" as Professor Laski maintains?

On this question the physician with an extensive consulting and hospital practice is in a position to pass judgment. He is intimately acquainted with the problems of the active practitioners in his own locality. While it may be possible that his locality is not representative of the country as a whole, frequent contacts with colleagues at national conventions and otherwise make him feel that it probably is. His first hand familiarity with the work of his local confreres makes his opinion in this matter of much greater weight than that of a layman, however well versed he may be in general social and economic problems. Let us then, through the eyes of such a physician, examine the average practitioner in one of the fairly large eastern American cities as well as in the adjoining towns and countryside. Our first impression is that he is a rather admirable fellow who quietly gives evidence of being well trained and up to date, though we note a few glaring examples of the opposite. He is quite evidently high in the esteem and affection of his patients. Is he, as he has been called, "a prisoner serving a life sentence"? Hardly—in fact quite the reverse. Held down by heavy responsibility he certainly is, but he carries it gaily and is quite his own master. On occasions he is able to negotiate with colleagues for mutual help in arranging vacations, trips to medical centers and the like.

Is such a man dependent upon factors extraneous to his purely technical skill in making his way? He most certainly is, but these are not social accomplishments, an attractive wife or skill at golf, but rather what we may call his personality—his ability to make people like him and what is more important, trust him—his ability to be sincerely kind, thoughtful and understanding. Without these qualities scientific skill is wasted, for, as every practitioner knows, the art is of equal importance with the science of medicine. To be effective medical advice and treatment must be given with kindness

and with care—always with the knowledge that the sick human being is frightened and impressionable, and that the fear and discouragement caused by a chance word may nullify weeks of effort. To the average patient not under an anaesthetic, what is said is often of more importance than what is done or prescribed. The achievements of such a man as William Osler depended fully as much on his benevolent understanding of human nature as on his strictly scientific ability. If all this be true, what is the effect on our average practitioner of his independent status with its lack of financial security? It is just this: He realizes that he must treat the Joneses, the Browns and the Smiths kindly, considerately and effectively or they will at once forsake him for his colleague around the corner. What if he had "security"? He could then afford to slight his patients a bit and the quality of his work would inevitably suffer.

Then there is the alleged inability of the average practitioner to keep up to date. In every urban and most rural communities hospital facilities are available with charity work to be done and always a place for the man who is well trained and willing to work. Opportunities for continued training and daily contact with the best type of work are thus within the reach of a very large proportion of the profession. For those to whom, because of residence in remote districts, such hospital positions are not available, there are the bi-weekly and monthly clinical meetings open to all practitioners, the duty of reading current medical literature and the routine contacts with consultants, which keep a man's interest stimulated and his information up to date. It is true that there are men who because of financial stringency are unwilling to risk attending meetings lest they lose a patient to a colleague. In many such cases the true reason for their non-attendance is intellectual inertia and a call at their offices next day is likely to disclose the fact that they have gone fishing or to the races. Furthermore, at the present time public education in medical matters is reaching a point such that the man who is known not to keep up, not to hold hospital appointments and not to call consultants freely suffers by comparison with his more progressive colleagues and by his short-sighted conservatism, defeats his own ends.

A few years ago a young man with average training entered general practice in a suburban community in which several older physicians had been established for years. He had no financial backing except what he was able to borrow. He obtained an opportunity to work in the Out-Patient Department of the largest general hospital in the adjoining city (an opportunity which, by the way, has always been open to any graduate of a good medical school who is licensed to practice in the state). Faithful work made his position permanent and thus brought him frequently in contact with the leaders of his profession. In his office his physical examinations were complete and well recorded as had been taught him by those poorly paid young enthusiasts who helped transmit to him his heritage of idealism along with his routine training in medical school and hospital. His problem cases always received adequate study, with laboratory work as needed either by himself or when necessary with the aid of the State Laboratory—a service free to physicians. His patients who needed it were urged to go to the hospital rather than be inadequately treated at home, and he called consultants whenever their help was needed even if he had to cut down his own fees to help the patient pay for the consultations or in rare instances to ask the consultants, whom he had come to know and trust, to join him in giving charity to a person in need. What has been the result? He has won the confidence of his community, people who in England would be called "lower middle class" who have been quick to recognize the difference between his painstaking methods and the slip-shod work of his older colleagues; and it may be added that he now owns his house and has all the work that he can do. This man is a typical product of the present system. Under State medicine, lacking the necessity to do his level best, it is probable that he could not, or at least that he would not have reached his present level of perfection as a practitioner. His counterpart is seen in most American communities although it must be admitted that he is superior to the "average practitioner" who has been the main object of this discussion.

If then we admit that under the present system there is ample opportunity for the earnest practitioner to develop himself and every incentive to render good and up-to-date service—we must still answer the charge that there is in actual practice often a great contrast between the treatment accorded the rich and the poor. This criticism is many times justified. The present system of free and low priced hospital beds for the needy is a

partial but by no means adequate answer. It is a commonplace that self-respecting people of moderate means who will not accept charity often fail to receive proper attention, as the cost of x-ray examinations, consultations and other forms of special investigation and treatment is prohibitive. Earnest efforts to improve this situation are being made as, for example, the establishment of hospitals in which a fixed low price is charged, such as the Baker Memorial Hospital in Boston. The questionable success of that form of partially socialized medicine, the British Panel System, which has been developed to meet this need is a warning that an ill-considered scheme may be worse than none at all.

Professor Laski cites the example of the rich man charged with drunken driving who can bring a private physician to his aid to counter police evidence. In this connection it is of interest that in the town where lives the successful young practitioner whose work has just been discussed a very rich man was recently taken up, charged with driving while under the influence of liquor. As allowed by law he summoned his own physician, a well known consultant, who examined him elaborately and found his condition to be normal at the time of his examination. In court it was discovered that this doctor had attended the judge and was known and respected by him. Yet, in spite of his testimony, the man was convicted, heavily fined and deprived of his license to drive, and the large fee which he had to pay to his physician availed him nothing.

Of other criticisms often aimed at physicians that which relates to what is known as "medical etiquette" is one of the commonest. In spite of a strong conviction among the laity to the contrary this etiquette, so called, seldom causes hardship to the patient and is a means of preserving harmony and understanding between physicians where a lack of such harmony might easily be the cause of untold havoc. When doctors work at cross purposes it is the patient who suffers. The commonest complaint of the layman is that he cannot have the doctor whose services he desires. For example, Doctor A refuses to treat him now that Doctor B, his family physician, has returned from his holiday—or because Doctor A has been Doctor B's consultant in the case. The simple fact is that a misunderstanding between Doctors A and B would be a real calamity and that the patient can always dismiss them both and call in Doctors C, D or E who will respond with no offence to anyone. If, as in such an instance, there arise occasional circumstances under the present system in which a slight limitation of absolutely free choice of a physician exists, we must remember that State medicine means a much greater limitation. Even "in the panel system, we have in the past few years, seen the patient's liberty to change his doctor greatly restricted" to quote from the writings of an English colleague. So much for "medical etiquette"—hardly the "labyrinth of complicated punctilio" that it has been called.

As regards the cults, Osteopathy, Chiropractic and the rest, honest endeavors to find the truth about them have brought to light so much crass commercialism and such a lack of demonstrable scientific foundation that the physician can only deplore the gullibility of the public. He must recognize, however, that further improvement in medical practice and the resulting increase in public confidence is the only means at his disposal for combatting these evils, and that all attempts at direct opposition will be interpreted as persecution. It is difficult to see in what way the establishment of State medicine would improve the situation.

If, then, the work of the physician today under the system of independent private practice is not on the average so poor; if, in fact, he is doing increasingly better and more scientific work as the years go by, fulfilling, as he must, higher and higher technical requirements to be admitted to practice and preserving, as he does, the lofty ideals that are his heritage—one can hardly say that the profession of medicine is in a state of "decline." If we admit the existence of many evils still to be corrected, we can still claim the existence of an honest effort in this direction. As far as the evil of commercialism is concerned, while we may agree that many shameful instances exist, we can still hold that in the rank and file of the profession the profit motive is subordinated as it is in no other group of independent individuals.

To really improve such a situation a plan for State medicine must be a very perfect one. Anything which limits the free choice of his physician by the patient will be a step backwards, and anything which takes away from the physician the necessity of "making good" in the eyes of his patient and of giving him his level best of attention and kindness as well as of technical skill will be retrogression indeed. Anyone who has had experience with medicine as practiced in the great public services, the Army and Navy, realizes that the

situation there is far from satisfactory from both these points of view. Let us mention only in passing the possibilities of gross injustice that are ever present under any sort of bureaucratic control and in this connection let us quote the words of another Englishman, the present Lord Chief Justice: "The treatment of the panel doctors under the National Health Insurance Acts is pure despotism."

In conclusion we may freely admit that socialization of society in general is highly desirable however difficult it may be to attain. We may further admit that if it could be successfully applied to medicine, socialization would represent an advance over the relatively satisfactory and consistently improving situation which it obtains at present. Every right-minded physician would be glad to be rid of the commercial side of his practice. Nevertheless we must bear in mind the immense difficulties in the way of success in this field and the positive harm that must result from anything short of success. Therefore, in view of the fact that in no group of independent individuals in our modern civilization is the profit motive less prominent and the need of socialization less urgent than it is in the medical profession, while at the same time in no group is socialization less likely to achieve success, we are forced to conclude that the field of medical practice is not the place to make the start.

PHYSIOLOGICAL SURGERY OF THE NERVOUS SYSTEM*

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There are three general types of surgical operations; those aimed at removing pathological structures, such as tumors or abscesses, those aimed at restoring normal anatomical relationships, in which group belong most orthopedic and plastic operations, and finally, those designed to correct or compensate for physiological or functional disturbances. In the surgery of the nervous system, as in other branches, operations of the first type are the most common. Operations of the second type are represented only by nerve sutures, for regeneration does not take place in the central nervous system. But operations of the third type, extremely rare in other departments of surgery, are assuming an increasing importance in the domain of neurological surgery.

The most important of these operations are those for the relief of pain. Simple peripheral neurectomies are now seldom used, the important exception being section of sensory nerves supplying the foot in the treatment of endarteritis. Posterior root section is sometimes indicated in selected cases of pain in the neck and trunk. Of course, allowance must be made for the overlap of neighboring dermatomes. The operation is most frequently performed for the relief of trigeminal neuralgia, and it represents one of the major surgical triumphs of the century. Modifications of the operation permit retention of sensation in unaffected branches of the trigeminal nerve. A recent substitute for the operation which holds great promise consists of the insertion of a needle through the foramen under anesthesia by means of X-ray control, and the destruction of part or all of the ganglion by chemical or physical means. This obviates the discomfort and loss of time occasioned by the operation, and all of the pain and most of the uncertainty of the old alcohol injections.

Operations have also been performed on the spinal cord for the relief of pain. The most important of these is section of the anterolateral columns, which is an extremely effective and surprisingly innocuous method of treating intractable pain in the pelvis, legs, and abdomen. It is less successful in the treatment of pain in the arms, but recently an operation has been introduced by which the "pain" fibers may be severed by a midline incision through the commissure, where they are crossing to enter the spinothalamic tracts, which has yielded good results.

Among other disagreeable sensations, the vertigo of chronic labyrinthitis has been treated with great success by section of the eighth nerve. A more conservative operation recently introduced consists in destruction of the semicircular canals in the petrous bone through the middle fossa—a technically easier and safer operation. Severe tinnitus may be relieved by similar means.

Of motor phenomena, epilepsy is the one which has been the object of countless surgical procedures, with occasional successes. The subject is too large to go into here. Severe torticollis is often satisfactorily relieved by section of both spinal accessories and two or three anterior cervical roots on

*Delivered at the Arnold Laboratory of Brown University at a Medical Colloquium under the Division of University Health.

both sides—an operation which leads to astonishingly slight disability. Recently athetosis and dystonia have been successfully treated by section of extrapyramidal motor tracts in the spinal cord.

An entirely different type of problem, which in the past has been considered hopeless, is presented by non-obstructive or idiopathic hydrocephalus. This has been relieved in many instances by resection of the choroid plexuses by open operation. The mortality is high, however, and much cortical damage is inevitable. A promising new procedure which is certainly far safer and apparently quite as successful, consists in the coagulation of the choroid plexuses through a special endoscope.

THE DIAGNOSIS AND MEDICAL MANAGEMENT OF DIAPHRAGMATIC HERNIA*

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This contribution is based on clinical observations made in the examination and treatment of patients presenting vague symptoms of dyspepsia, in whom, in the course of study of the alimentary canal, a diaphragmatic hernia of the esophageal hiatus type was encountered. Such a hernia may be described as a protrusion of a portion of the fundus of the stomach, occasionally with other abdominal viscera, into the thoracic cavity through the esophageal orifice of the diaphragm. The opening in the diaphragm may be other than the esophageal orifice; it may be a natural opening which has become enlarged or an artificial one acquired by injury.

Giffin[1] found 650 diaphragmatic hernias reported in the literature up to 1912. Most of these cases were discovered at autopsy and but 15 had been correctly diagnosed clinically. In 1924, Carman and Fineman[2] reported 20 cases observed at the Mayo Clinic up to then and estimated that the incidence was 1 in 18,000 patients. Within the past 10 years, numerous cases have been reported by Hedblom,[3] Akerlund,[4] Harrington[5] and Truesdale;[6] the last named reporting a large series of surgically treated cases in both children and adults.

During the past 12 years, in both hospital and private practice, I have observed 53 cases of esophageal diaphragmatic hernia in about 6,000 patients with gastro-intestinal complaints, an incidence of 1 to 113. The diagnosis in all of these cases was made definite with the aid of the Roentgen ray. The age and sex of the patients in this series is shown in Table I. The majority of these patients are of the age when one may suspect ulcer, cholecystitis, cardiac disease, cancer of the alimentary canal, or pernicious anemia.

Table I

AGE AND SEX INCIDENCE

	Cases	Males	Per Cent	Females	Per Cent
20 to 30 years	3	3	100		
30 to 40 years	7	2	29	5	71
40 to 50 years	20	5	25	15	75
50 to 60 years	16	4	25	12	75
60 years and over	7	3	43	4	57
Total	53	17	32	36	68

Diaphragmatic hernia is of interest to the internist, the surgeon and the roentgenologist because the symptoms frequently may be obscure and are easily confused with those of other diseases. Its possible presence should be always considered in the differential diagnosis of abdominal and thoracic conditions and in unexplained anemia. Anemia in these cases is due to mild but frequent hemorrhage from erosions of the mucous membrane, especially during attacks of vomiting or severe coughing. The erosions are caused by mechanical injury to the stomach because of its unnatural situation, or by interference with its blood supply due to the stricture at the esophageal orifice and may progress to actual ulceration and occasionally to carcinoma. Truesdale,[7] Harrington,[8] Hurst[9] and Schilling[10] report cases of ulcer formation within the constricted area of the stomach. I have observed two cases complicated by gastric ulcer, one in a man aged 55 and the other in a man aged 70; the latter developing carcinoma at the site of the ulcer three years later. Another gastric cancer associated with a diaphragmatic hernia was seen in an elderly woman. Bock[11] reports 10 cases of secondary anemia caused by bleeding in cases of diaphragmatic hernia.

Most of the correctly diagnosed cases have been reported within the last ten years. This has been due to the better appreciation of these cases by the

*Read in part before the Rhode Island Medical Society, March 1, 1934.

*Read before the Section on Gastro-Enterology and Proctology at the Eighty-Seventh Annual Session of the American Medical Association, Kansas City, Mo., May 15, 1936.

clinician in differential diagnosis of vague complaints referred to the upper abdomen and lower chest, to the improved methods of Roentgen ray diagnosis, and to the more painstaking abdominal exploration by surgeons during operations for other conditions.

The classifications of diaphragmatic hernia are based on embryology, etiology or pathological anatomy. The classification of Dr. Stuart W. Harrington[3] is probably the best since it takes into consideration the clinical history, which may be the most important factor in diagnosis and treatment. This classification consists of two main groups: the Non-traumatic, which may be congenital or acquired, true or false; and the Traumatic, due to direct or indirect injury, also true or false.

Akerlund[4] classifies esophageal orifice herniae into three sub-groups: those with a congenitally short esophagus, producing the so-called "thoracic stomach"; the para-esophageal type in which the lower end of the esophagus remains fixed and variable amounts of stomach herniate through the ring along side of it; and those in which the lower end of the esophagus with more or less of the stomach prolapses through the opening. Thoracic stomach is a very rare occurrence. The majority of the cases reported belong to the last two sub-groups.

Etiology and Pathogenesis of Symptoms

Diaphragmatic hernia is due to congenital weakness or to mal-development of the diaphragm, to increased intra-abdominal pressure, or to trauma. Females are more likely to acquire an esophageal diaphragmatic hernia than males. Embryologically, the stomach is a thoracic organ which later migrates into the abdomen. The various parts of the diaphragm meet and fuse together leaving small openings for the passage of the aorta, the large blood vessels, the esophagus and the nerves. Delay in the descent of the stomach at the time the diaphragm fuses may cause a part of the stomach to remain in the thoracic cavity. There may be an enlargement of the esophageal opening of the diaphragm creating a congenital weakness in the esophageal ring. This predisposes to hernia formation either at birth or at any time during life.

Diaphragmatic hernia may arise as the result of increased intra-abdominal pressure, of which the most common causes are sudden and severe trauma to the chest or abdomen, pregnancy, constipation, severe coughing or straining, prolonged physical exertion, chronic cough, hypertrophy of the prostate, wearing of tight corsets, ascites, kyphosis and megacolon.

Most diaphragmatic hernias are found on the left side. This may be explained by the fact that the right side of the diaphragm is protected from below by the liver. The left side is constantly in contact with the stomach which by its free motility tends to expose the left side.

The size of the hernia depends on such factors as the width of the opening in the diaphragm, the habitus of the patient, the degree of intra-abdominal tension and the amount of food and gas in the stomach. The size of the hernia also varies with the position of the patient, being largest in the recumbent position and smallest or entirely absent in the erect position. Some of the herniae in my series have been observed over a period of ten years with no apparent increase in size. Nearly every organ in the abdomen except the rectum and the bladder have been reported to herniate through the diaphragm. Usually, however, the stomach alone, very rarely the colon alone, and occasionally the stomach and the colon together are found in the hernial sac.

The presence of a hernia in the thoracic cavity displaces the organs normally situated there and may cause cardio-respiratory symptoms. The content of the hernia may displace the heart toward the right and in severe cases causes collapse of the left lung. The hernia may give rise to severe digestive symptoms that may simulate peptic ulcer, gastric cancer, esophageal obstruction, gall-bladder disease, pancreatitis, appendicitis, intestinal stasis and obstruction. Spasm of the diaphragm, with obstruction to the blood supply of the herniated portion of the stomach, may occur and predispose to erosions, ulcerations or "hour-glass" deformity of the stomach or interference with its motility. The hernia may encroach upon the lower portion of the esophagus and cause dysphagia, erosion or ulceration of the esophagus. The pressure of the hernia on the lower esophagus may also interfere with eructation or vomiting. As the majority of the cases seen are in the cancer and ulcer age, a clinical diagnosis of cancer or ulcer of the esophagus or stomach may seem perfectly reasonable. A spasm of the left side of the diaphragm, associated with irritation of the phrenic nerve, may cause pain of a severe type radiating to the left shoulder and down the arm, simulating an attack of angina pectoris. Symptoms of cardiac impairment such as palpitation, tachycardia and cyanosis may be present.

Symptoms

The symptoms of a diaphragmatic hernia are frequently indefinite and readily confused with those of other disease entities. This is due to the various structures that are involved in the hernia, its size and the degree of encroachment upon the thoracic organs. The symptoms in each case therefore depend on the functional impairment of the herniated abdominal viscera or organs, the degree of impairment of the normal function or motion of the diaphragm, and the degree of pressure which the hernia exerts on the surrounding structures in the thoracic cavity: the heart, lungs and esophagus. Table II illustrates the variability of symptoms in diaphragmatic hernia. In some cases, the symptoms may be very mild and easily overlooked, the condition may be accidently found in the course of a Roentgen ray examination of the digestive tract, of the chest, or in the course of exploration during an abdominal operation. Not infrequently cases have been reported where the first symptoms of a hernia of years' duration were those of acute obstruction. When symptoms are present, they may be cardio-vascular, respiratory, gastric or abdominal. When the symptoms are thoracic, cardio-vascular disease, pulmonary tuberculosis, and other lung conditions are usually suspected. The patients commonly complain of substernal distress, a sense of fullness or pain of a pressing nature, varying in degree. The pain may radiate to the back, the sides, and the left shoulder and arm. Twelve patients of this series presented symptoms of severe attacks of substernal pain with radiation to the back, neck, left shoulder and left arm, and were often treated for angina pectoris without relief. Quite often the patient notes that the symptoms are aggravated by the ingesion of either a small meal of coarse food or a full and heavy meal. Many patients avoid lying down immediately after meals for fear of initiating an attack. Belching, bloating, nausea and vomiting may be associated symptoms. Ten patients of this series often required morphia during the attacks. Indeed, the pain may be so severe and agonizing that a diagnosis of biliary colic is made. Some patients obtain relief by taking hot drinks, alkalies, by taking a rest in a semi-erect posture or by walking around intermittently during the meal. These measures often prove effective because during meals these patients experience substernal distress due to the hernia beginning to fill with food. Taking a warm drink, resting, or getting up and walking around for a short while gives the hernia a chance to reduce itself with a resultant disappearance of symptoms. Ritvo[12] found this to be a helpful sign in the diagnosis of diaphragmatic hernia. In many cases the attacks may occur periodically with distress simulating the pain of peptic ulcer. Regurgitation, heartburn, gas, belching and vomiting are frequently complained of. Hematemesis is not an infrequent occurrence and occult blood in the stool may be detected at times in about one-half the cases thus leading one to suspect the presence of an ulcer or gastric cancer.

Table II

Symptoms	Number of Cases	Per Cent
Postprandial distress or pain	48	90
Substernal distress or pain	43	81
Upper abdominal distress or pain	37	70
Nocturial distress or pain	35	66
Alkali relief	33	62
Vomiting	28	53
Heartburn	27	51
Bloating and belching	25	47
Weakness	23	43
Dyspnea, palpitation, tachycardia or cough	22	42
"A lump in lower throat" or dysphagia	14	26
Hunger pain	12	23
Anemia	12	23
Hematemesis	11	21
Tarry or black stools	9	17
Loss of weight	8	15
Overweight	6	11
Constipation	6	11

In diaphragmatic hernia the appetite is generally not impaired, an important point in the differential diagnosis between diaphragmatic hernia and carcinoma. The weight loss, if present, is due to voluntary abstention from food for fear of initiating an attack. There may be attacks of vomiting and at times hematemesis. The presence of blood in the vomitus is due to inflammation or erosions of the gastric mucosa in the herniated portion of the stomach, to the presence of gastric ulcer or to erosions or ulcerations in the lower portion of the esophagus.

The symptomatology most frequently encountered in these cases simulates, in order of frequency: peptic ulcer, gall-bladder disease, cardio-vascular disease, disease of the esophagus and pernicious anemia.

Physical Signs

In the small, uncomplicated hernias physical signs may be entirely absent. In the large hernias the physical signs are chiefly thoracic, due to the encroachment by the hernial content upon the thoracic organs. Pneumo-thorax, hydro-thorax or a new growth may be suspected. Displacement of the

heart toward the right, especially after the ingestion of a large meal, is often observed. In some cases, the auscultatory and percussion sounds can be made to vary by changing the position of the patient or by the ingestion of food or large quantities of fluid. Borborygmus over the thorax, if present, is a valuable sign and is considered by some observers as pathognomonic of a diaphragmatic hernia. The affected part of the chest may appear enlarged and the abdomen occasionally may be found retracted. There may be tenderness in the upper part of the abdomen.

Table III

Associated Diseases	Number of Cases	Per Cent
Peptic Ulcer: Gastric 2, Duodenal 10	12	23
Cholecystitis, Cholelithiasis	12	23
Hernia: Inguinal 10, Umbilical 2	12	23
Chronic Appendicitis	9	17
Irritable Colon	7	13
Diverticulosis	6	11
Uterine Fibroids	3	6
Cardio-vascular Disease	3	6
Prostatic Hypertrophy	2	4
Cancer of the Stomach	2	4
Diverticulum of Lower Esophagus	1	2
Pernicious Anemia	1	2

Diagnosis

Roentgenological studies are indispensable for a diagnosis and therefore should be employed whenever diaphragmatic hernia is suspected. Many of these cases have been diagnosed only after one or more abdominal operations without relief of symptoms. Rarely is the hernia seen fluoroscopically with the patient in the upright position because the hernia is often reduced in that position. It is best observed by examining the patient in either the recumbent or Trendelenburg position. At times it may be demonstrated best by rotating the patient quickly from side to side, by deep inhalation and exhalation, straining, inflating the colon, producing abdominal constriction or by manual pressure over the stomach. When the hernial sac contains a little contrast media the gastric rugae may be observed, conclusive evidence that a portion of the stomach is above the diaphragm. One should note during the Roentgenoscopic examination whether the hernia reduces itself by change of position from lying to standing, by rotation, or by palpation, as these facts may be helpful in determining the presence or absence of adhesions and the possibility of incarceration or strangulation.

Roentgenologically, in the differential diagnosis, we must bear in mind the following conditions: (1) diaphragmatic hernia involving other than the esophageal orifice; (2) congenital shortening of the esophagus; (3) esophageal diverticulum involving the lower end of the esophagus; (4) cardio-spasm; (5) cardio-esophageal relaxation; (6) eventration of the left side of the diaphragm; and (7) diverticulum of the cardia of the stomach. Symptomatically, we must differentiate diaphragmatic hernia from peptic ulcer, gastric and esophageal cancer, gall-bladder disease, secondary anemia, reflex disturbances of the stomach caused by an irritable colon, and hyperchlorhydria; also from those thoracic conditions simulating it: pleurisy with effusion, pneumo-thorax, pulmonary cavitation and cardio-vascular disease.

Treatment

The treatment of diaphragmatic hernia requires careful consideration and study. The well being of the patient as a whole, rather than the prescribed treatment for the hernial condition, should be uppermost in the mind of the physician. Since many of these cases present the syndrome of peptic ulcer, gall-bladder disease or unstable colon, measures that are found successful in the treatment of those conditions often prove effective. In other words, the medical treatment is largely symptomatic. Since many of these patients have periods of quiescence and recurrences, the factors underlying these periods are of great importance. Attacks may be brought on by nervous and emotional upsets, states of mental and physical fatigue, and unhygienic habits. Many small hernias do well under medical treatment the aim of which is the avoidance of anything that is likely to increase intra-abdominal pressure. Food should be of a bland nature, taken in small amounts, at frequent intervals and eaten slowly. Complete co-operation of the patient is just as important in the treatment of this condition as in the successful management of peptic ulcer, diabetes, and pernicious anemia. If distress occurs during a meal, getting up and walking about for a few minutes will bring relief. Warm drinks and alkalies are also helpful. Anti-spasmodics and sedatives are frequently valuable. Tobacco should be forbidden entirely. The patient should be advised against retiring after a full, heavy meal at night and should preferably sleep with his head raised by several pillows, most of the time on his right side. If anemia is present, appropriate treatment should be prescribed.

Avoidance of strenuous exercise, heavy lifting, constipation, cathartic abuse, obesity and other con-

ditions that increase intra-abdominal tension is of great importance in the medical management of diaphragmatic hernia. Associated pathological entities such as peptic ulcer, diseased gall-bladder, irritable colon, chronic appendix or large pelvic tumor should receive proper treatment as they unquestionably cause aggravation of the hernia by reflex irritation of the stomach. Three patients of my series were completely relieved of symptoms after the removal of large uterine fibroids.

In the larger hernias with severe symptoms, not amenable to medical treatment, surgery is advisable if the condition of the patient permits. Operation should be undertaken only after serious study and consideration. Surgery in the treatment of diaphragmatic hernia even in the hands of the most competent surgeons is associated with a moderately high mortality and the possibility of recurrence. In only four cases of my series was surgical treatment necessary. It may be noteworthy that one of these patients, who in 1933 had the hernia repaired through the thoracic approach, had a recurrence of the hernia after a fall about six months later, but since has had only mild symptoms which respond to medical treatment.

In the traumatic cases the patient may be in severe shock and on examination a large part of the stomach and other abdominal viscera may be found in the chest. Such cases should be treated as any acute traumatic emergency without unnecessary delay.

Summary

This contribution is a clinical résumé of 53 cases of non-traumatic esophageal diaphragmatic hernia seen during the past 12 years. Numerous accounts of this clinical entity have been contributed by the Roentgenologist and surgeon but very few contributions have originated from the clinician although he, in most instances, is the first to see these cases.

The apparent increase in the reported incidence of diaphragmatic hernia is in reality due to the better appreciation of these cases by the clinician in differential diagnosis of vague complaints referred to the upper abdomen and lower chest, to the improved methods of Roentgenological diagnosis, and to the more painstaking abdominal explorations by surgeons during operations for other conditions.

The symptoms of diaphragmatic hernia are usually complex, slowly progressive and vary in type and intensity. They may be thoracic or abdominal in nature and at times they may be entirely absent and the discovery of a hernia, purely accidental. The symptoms present may simulate disease conditions of the abdomen and thorax.

We are justified in making a provisional diagnosis of diaphragmatic hernia on the basis of presented symptoms. A definite diagnosis of its presence must always be confirmed by careful Roentgenological study, unless this is contra-indicated.

The medical treatment of diaphragmatic hernia is largely symptomatic. Effort should be directed to the correction of associated disease conditions which may be largely responsible for the patient's complaints. Uncomplicated hernias do well under medical treatment. (Only four cases of this series required surgical intervention[2].)

Surgical treatment is advised when symptoms are severe and not controlled by medical management. The size of the hernia is no criterion in the decision for or against surgery. The possibility of carcinoma developing at the site of a gastric ulcer associated with diaphragmatic hernia is emphasized.

The importance of co-operation between clinician, Roentgenologist and surgeon in the diagnosis and management of diaphragmatic hernia cannot be over-estimated.

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THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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OUR HERITAGE

The resignation of Dr. Frederick N. Brown, for fifteen years Editor of the RHODE ISLAND MEDICAL JOURNAL, has been accepted by the Committee on Publication with the deepest regret.

It was in 1859 that the Rhode Island Medical Society voted that "a committee be raised to select and publish such papers in the archives of the society as they may deem worthy of presentation and also to prepare a sketch of the lives of eminent deceased physicians, from the first settlement of the colony, with an account of the medical institutions, and of other matters pertaining to the history of medicine in Rhode Island." The committee then raised, the original of the present Publication Committee, consisted of Usher Parsons, Isaac Ray and George L. Collins. So strenuous was their task that the report was published in 1877; a 474 page volume entitled "Communications of the Rhode Island Medical Society." Dating from the year 1859, the Society began publication of its *Transactions*, in parts issued quarterly and continued to the one hundredth Anniversary Meeting in 1912.

In January, 1900, the Providence Medical Association began to publish the bi-monthly *Providence Medical Journal*, with George D. Hersey, Editor, and Frederick T. Rogers, Business Manager. With these men in charge, the project could not but succeed. In 1912, by authority of the House of Delegates, it was made the Official Organ of the Rhode Island Medical Society and during the next four years published the papers and Transactions of the Society, edited successively by George D. Hersey, Frederick T. Rogers, and James W. Leech.

In November, 1916, the Journal was purchased by the Rhode Island Medical Society for the sum of one dollar and other valuable considerations, and in January, 1917, appeared as an enlarged monthly, RHODE ISLAND MEDICAL JOURNAL, under the editorship of Roland Hammond. In 1921, Frederick N. Brown undertook the office of Editor, which he was to continue for the memorable period of fifteen years. His resignation marks the end of the seventy-seventh year of the Rhode Island Medical Society's publications. We can still say, as did Dr. Hersey 38 years ago, in his first editorial, "As a matter of fact we are rather proud of the Journal, both of its appearance and contents."

Dr. Brown succeeded in office a notable line of editors, and, throughout his long term of service, has upheld the traditions of the Journal and of the Society. He has performed this task with tact and efficiency, and, through hearty and genial co-operation, has endeared himself not alone to those whom he has chosen as associates in the conduct of his office, but to the officers and fellows of the Society, with whom his position has brought him into frequent and intimate contact.

"DOCTOR"

In the future it may be an honor for a physician to be called "mister" as it is in England for surgeons. It just doesn't work to call these surgeons doctors. The title "doctor" means so little nowadays. In France, doctors are addressed "monsieur" or "monsieur le docteur," but the simple title doctor means little. Anyone who holds a doctor's degree is quite apt to use the title—clergymen, Ph.D.s, optometrists; and of course they are entitled to it. Perhaps we should be content to let patients speak of us as "doc" to distinguish ourselves from the "doctors" who are being created—faster than rabbits ever bred.

So much medical stuff and all of it so rotten. The *Pathfinder* magazine carries ads for cures for piles, epilepsy, gallstones, prostatic disease, alcoholism, asthma, how to get a baby, blood pressure, arthritis, sores and lumps. Doctor's shoes are advertised to a weary public. Of the five nationally advertised brands of "doctor" shoes, three are creations of now-deceased chiropodists who were not medical men. The *Shoe and Leather* Record, of London, states that the "doctor" brands of shoes "are based upon 'bolony'." The Tugwell amendment to the new Food and Drugs Act would have made shoes technically "drugs" but there are too many interests involved to permit such a bill to pass.

Built-in arches, all sorts of devices to deceive the public, can do more harm than good since each foot is different. It is impossible to prescribe a shoe to fit every need. Pathetic is the pilgrimage to Canada for foot twisting. Some New York hotels announce that buses run daily from New York to the Canadian joint. No doubt the psychologic effect is of benefit to some but when one sees a woman chasing over the roads for this sort of treatment when she is actually suffering from peripheral vascular disease it is pathetic to say the least.

M. W. T.

THE EDWIN SMITH SURGICAL PAPYRUS, WITH SOME REMARKS UPON EGYPTIAN MUMMIFICATION*

This papyrus, recently translated by Professor Breasted of the University of Chicago, has revolutionized our ideas of pre-Hippocratic surgery. It is an unfinished copy, made about 1700 B. C., of forty-eight cases of injury. The original observations were probably made in the IIIrd Dynasty and *may have been* made by Imhotep, or his immediate successors. The cases are arranged in rational fashion, beginning with minor injuries of the head, going on to the more severe, and progressing from the head to the thorax, where our copyist leaves off in the middle of a sentence. There is no magic whatsoever, but scientific, logical reasoning from cause to effect. The surgeon describes general and local signs and symptoms, gives either one of three prognoses: an ailment to be treated, to be contended with, or an ailment not to be treated, and then proceeds to recommend what would be considered quite modern handling of each case.

Mummification must have played some role in Egyptian conception of anatomy as the Egyptians were the only ancient people to remove the viscera after death. A study of the evolution of the technique shows gradual perfection up to the XXth Dynasty, then deterioration, with more attention paid to the external wrappings than to the preservation of the body itself. X-ray examination of five mummies in the Boston Museum of Fine Arts corroborated the studies made by Ruffer, G. Elliot Smith, and others.

C. A. McD.

*Breasted, James Henry. The Edwin Smith Surgical Papyrus. University of Chicago Press, Chicago, Ill., 1930. Smith, G. Elliot and Dawson, Warren R. Egyptian Mummies. London: George Allen and Unwin, Ltd., 1924.

STREET LIGHTING

The apparent purpose of lights along the streets and highways is to protect the pedestrian. In general the lights are bright and unshaded. Every driver has had the sensation of relief on going from a lighted road to an unlighted one. These unshaded lights exactly defeat their own purpose. Light falling on a plane polished surface is regularly reflected, light falling on a dusty windshield (and whose windshield is not dusty?) is diffusely reflected, the greater part of the light being turned back in a definite direction. Auto lights by law are so shaded and reflected that they cause a minimum of glare under the circumstances.

Street lights are placed in such a position that a lateral beam is reflected from the windshield. This creates a zone between the street light and the approaching auto light, the center of which is occupied by the pedestrian. This zone has a very low visibility. On a rainy night where the dispersion of light is great, from the tiny rain drops, it is practically impossible to see a pedestrian walking beside the road. There is another angle too, in the problem of unshaded street lights. They cause a glare on the pupil of the eye which makes it contract. Thus the eye is a less efficient organ with which to see objects at the side of the road.

It would be interesting to examine the statistics of pedestrian accidents to find out what proportion of injuries occurred on unlighted streets as against those on lighted highways. Has it occurred to the various departments of safety to investigate this problem? A careful study of reflection of light, visibility of objects beside the road under various conditions, and the effect of unshaded lights along the road upon the pupils of the eyes of drivers, might bring up some worthwhile reforms in the way of street lighting.

Given a rainy night, with auto lights approaching, and a chain of unshaded street lamps on one's right, a pachyderm of noble proportions would be no more visible to the eye of a driver than one of Singer's midgets.

The reasonable solution of this problem would be street lights, with a softly colored shade, lighting the side of the road for the pedestrians' use, not a glaring, much diffused beam of light which seems to cast a Stygian umbra in the very place that needs good illumination most.

G. L. Y.

Rhode Island Hospital

On December 3, 1936, Dr. John S. Dziob of Woonsocket and Harvard Medical School, 1934, became Resident Physician at the Jane Brown Memorial. His internship at the R. I. Hospital terminated December 1.

Dr. Edward F. Ruhmann of Boston University Medical School, 1932, has opened an office for general practice at 1620 Broad Street. Dr. Ruhmann interned at the R. I. H. from February, 1933, to October, 1934, and was Resident Physician at the Jane Brown Memorial from October, 1934, to December, 1936.

Born on December 10, at the Lying-In Hospital, to Dr. and Mrs. McDougall, a daughter. Dr. McDougall is an intern at the R. I. H.

On December 15, 1936, Dr. Henry A. Campbell, of Central Falls, R. I., and Harvard Medical School, 1936, started a two year internship at the R. I. H.

Dr. and Mrs. Joseph F. Hawkins have gone to Florida for the Winter.

Drs. Shaw and Pickles have resumed practice after their recent illnesses.

Dr. Forest Martin was a recent visitor at the Hospital.

Dr. Herman A. Winkler is taking a post-graduate course in Bronchoscopy under Professor Chevalier Jackson at Temple University in Philadelphia. Dr. Winkler expects to resume practice about December 28, 1936.

In the *Journal A. M. A.* for December 19, Dr. Ralph Purvine has a well written report on "Fatal Poisoning from Sodium Dinitrophenol."

Providence Lying-In Hospital

At the regular Staff meeting, Wednesday, December 9, 1936, Dr. Alonzo K. Paine of Boston, was the guest speaker. He discussed a new method of the operative delivery of persistent posterior positions and illustrated the lecture by a number of excellent lantern slides. The method is a modification of Scanzoni manoeuvre in that forceps are applied upside down in the position in which the posterior occiput lies, and the head is brought down to the perineum outside of the bony pelvic outlet and then rotated to the anterior with the forceps, which will then lie in the correct position for delivery. This obviates taking off and reapplying the forceps, but one application being made. Doctor Paine is Professor of Obstetrics at Tufts Medical School. A film from the Chicago Lying-In Hospital showing the technic of forceps operation was shown.

Dr. Donald M. Beckwith, of Port Jefferson, Long Island, N. Y., is now resident surgeon.

Dr. LeRoy H. Wardner, of Saranac Lake, N. Y., began his internship December 1.

St. Joseph's Hospital

The monthly meeting of St. Joseph's Hospital Staff Association was held on Thursday, December 10, 1936. The meeting was called to order by Dr. William R. McGuirk, Acting President. The minutes of the previous meeting were read and accepted. Analysis of Hospital Services for November, 1936, was read, discussed and accepted. The annual report of the Secretary was read. On motion made by Dr. John T. Ward and seconded by Dr. William Hindle, the report was approved and accepted as read. The annual report of the Treasurer was read. On motion made by Dr. Andrew Mahoney and seconded by Dr. Vincent Oddo, the report was approved and accepted as read.

New Business: A communication from the Medical Board announcing Dr. Edward F. Burke as President and Dr. James H. Fagan as Secretary-Treasurer of St. Joseph's Hospital Staff Association was read by Dr. William R. McGuirk, Acting President, and accepted.

The paper of the evening, "Bleeding in Pregnancy," was presented by Dr. Andrew Mahoney, Obstetrical Department, followed by Motion Pictures of Post Partum Hemorrhage and Treatment. Discussion was opened by Dr. Frank S. Hale, who spoke on the indications for interference and treatment. Dr. Hale brought out the important points in blood pressure, pulse pressure, shock index, blood count, in the management of a case. Dr. Edward F. Burke spoke on Utero-Placental Apoplexy, including symptoms, pathology and treatment. Dr. James S. Manley spoke on Hydatidiform Mole and Chorio-Epithelioma. He reported two cases followed by Hysterectomy. Dr. James Hamilton reviewed the pathology and advised on treatment, cautioned against being too drastic. Dr. Andrew Mahoney closed the discussion by bringing out the fine points and explaining the pathology existing, necessitating surgery in the cases reported by Dr. James S. Manley.

On motion made by Dr. Vincent Oddo and seconded by Dr. James Hamilton, the meeting adjourned.

* * *

Dr. James S. Manley of New Bedford, Massachusetts, Resident Obstetrician, has received an appointment at the Rotunda Hospital, Dublin, Ireland, beginning March 1, 1937. Dr. Manley graduated from Boston College, and Tufts Medical School in 1931. He interned in St. Luke's Hospital, New Bedford, Massachusetts.

Dr. James B. Moran, Providence, Rhode Island, began his internship on November 1, 1936. He graduated from Providence College in 1932, and graduated from the University of Maryland in 1936.

Dr. Malcolm A. Winkler has returned from a tour of the hospitals in New York City.

Homeopathic Hospital of Rhode Island

The third lecture in the series under the direction of Dr. W. Richard Ohler arranged for the General Staff meetings of the Homeopathic Hospital of Rhode Island was given at the hospital Tuesday noon, Dec. 15th, by Dr. H. Houston Merritt of the Boston City Hospital, the subject being "Neurology as Applied to General Medicine."

Dr. Merritt described the simple tests which should be done in a routine examination and explained their significance. These included tests involving the cranial nerves such as pupillary reflexes, examination of the fundus of the eye, differentiating nerve and conductive deafness, facial movements, movements of the tongue, voice; examination of the motor system, noticing gait, weakness of arm movements, and grip; sensory tests with brush or wisp of cotton, differentiating sensation, or absence of sensation from pressure of the head or point of a pin, tuning fork on the shin as an aid in determining cord lesion, Romberg's test, reflexes of the knee-jerk, ankle-jerk, and plantar response (Babinsky's test).

Special attention was given to combined system disease, or cord degeneration, with pernicious anæmia. Other subjects discussed were multiple sclerosis, spinal cord tumors, cerebral and vascular lesions, including syphilis, dementia paralitica, tabes, and the examination of the comatose patient.

Dr. William H. Foley, formerly of the Charles V. Chapin Hospital, began his service as interne in the Homeopathic Hospital in December.

Minutes of the Caduceus Club

The monthly meeting of the Caduceus Club was held at the T. K. Club, December 14, 1936. The meeting was called to order by the President, Dr. Thaddeus A. Krolicki. The minutes of the November meeting were approved. Dr. Robert Henry, Chairman of the Banquet Committee, reported that the second annual banquet of the Club would be held at the To Kalon Club on January 11, 1937. Dr. Berlin and Dr. Blumgart of Boston have been invited to attend. Three physicians were unanimously elected to membership: Dr. Charles H. Holt, Dr. James L. Wheaton and Dr. Albert Vandale. It was voted by the Club, on recommendation of the Educational Committee, to adopt a uniform method of examination in regard to food handlers. Tests for Luetic and Neisserian infection have been included in this examination. Dr. Farrell, Chairman of the Publicity Committee, reported a gratifying response on the part of the public to the medical lectures sponsored by the Club. In cooperation with the Club, local druggists have offered to advertise the current lecture bi-weekly under the name of their drug firm. A collation was served, after which the meeting adjourned.

Respectfully submitted,

GEORGE B. MCCLELLAN, *Secretary*

Charles V. Chapin Hospital

Dr. William H. Foley, who served a short internship at this hospital and was then, on March 1, 1936, appointed resident in the psychopathic wards, left on November 30 to accept an internship at the Homeopathic Hospital.

Dr. Vincent P. Rossignoli commenced an internship here on September 1, 1936, and takes Dr. Foley's place. Dr. Rossignoli is a graduate of Providence College and Georgetown University Medical School. He served a rotating internship at The Hospital of St. Raphael in New Haven before coming here.

Dr. Francis A. DeCesare of Cranston began an internship December 1, 1936. He is a graduate of Providence College and the University of Naples in Italy.

Emma Pendleton Bradley Home

Dr. Dorothy G. Sproul, who has recently completed a short internship at the Emma Pendleton Bradley Home, has returned to take up her duties at the Children's Clinic of the University of California Hospital, San Francisco.

Dr. Lewis J. Schloss, who completed a six months internship at the Emma Pendleton Bradley Home on January 1, 1937, has started an eighteen months rotating appointment at the Newark Beth Israel Hospital, Newark, New Jersey.

MEMORABILIA

[*L., neut. pl. of memorabilis, worthy to be remembered or noted.*]

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning experimental and clinical investigations relative to the thyroid gland. This award will be made at the discretion of the Society at its next annual meeting to be held in Detroit, Michigan, June 14, 15, and 16. The competing manuscripts, which should not exceed 3,000 words in length, must be presented in English and a typewritten double spaced copy sent to the Corresponding Secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania, not later than April 1, 1937. Manuscripts received after this date will be held for competition the following year or returned at the author's request.

On January 7, our Historian, Dr. Walter L. Munro, starts on a world cruise, visiting Trinidad, Bahia, Rio de Janeiro, St. Helena, Cape Town, Durban, Madagascar, Seychelles, Bombay, Benares, Ceylon, Bangkok, Penang, Java, Sumatra, Bali, Singapore, Manila, Hongkong, Shanghai, Peping, Japan, Honolulu, Los Angeles, Balboa, Providence after five months.

November 27. A regular meeting of the Jacobi Medical Club of Rhode Island was held at the Miriam Hospital Annex, Dr. S. J. Goldowski spoke on "Cerebral Injuries."

December 8. The Amos Throop Club was entertained by Dr. Murray S. Danforth with motion pictures in color, illustrating a vacation trip through Norway, Sweden and Denmark.

December 11. At the meeting of the William W. Keen Medical Club, entertained by Dr. Paul C. Cook, an interesting report on the Second International Congress Against Cancer, which they attended at Brussels on September 20-26, was given by Drs. Herman C. Pitts, B. Earl Clarke and Russell Bowman.

December 14. At the meeting of the Thirty Four Medical Club, Dr. Frank W. Dimmitt spoke on "Acute Laryngeal Obstruction." The discussion was opened by Dr. K. K. Gregory.

* * *

Wednesday, December 16. At the John M. Peters House of the Rhode Island Hospital, Dr. Jacob Fine of the Beth Israel Hospital of Boston addressed the Rhode Island Fellows and Associates of the American College of Physicians on the absorption of air and gases from body tissues and viscera by the use of ninety-five per cent oxygen. Dr. Fine described experiments on animals and observations on human beings which showed that if ninety-five to ninety-eight per cent oxygen be inhaled, the nitrogen tension in the alveolar air is greatly reduced, causing a passage of nitrogen from the blood stream into the alveolar air and a reduction of nitrogen tension in the blood. Nitrogen gas in an obstructed small intestine tends then to pass into the blood stream, thus reducing gaseous distension. In animals in which nitrogen or air is injected either into the tissues or into the small intestine marked absorption takes place when the animal is breathing pure oxygen as compared with an animal breathing air in which there is relatively little absorption. Experiments on the distended stomach, however, showed but little absorption regardless of whether the animal breathed oxygen or air.

Dr. Fine showed that nitrogen is the gas most frequently found in bowel obstruction and that if hydrogen or oxygen be injected a good part of such gas will be replaced by nitrogen. He presented data on several clinical cases of obstruction in human beings in which the breathing of ninety-five per cent oxygen for from twelve to twenty-four hours produced definite amelioration of distension. In discussing encephalography Dr. Fine showed that absorption of the air injected can be greatly facilitated by three or four hours of this type of oxygen treatment with marked relief of headache. Even if oxygen has been used for the encephalogram, he showed that it is replaced by nitrogen and the need of aid in the absorptive process remains.

At the meeting, Dr. Charles F. Gormly was elected Chairman, and Dr. Cecil Dustin, Secretary. Dr. Guy W. Wells was elected Chairman of a program committee of four members; Dr. Wells, Dr. Alex. M. Burgess, Governor of the College for Rhode Island, and the Chairman and Secretary of the Rhode Island group, ex-officio.

* * *

December 18. With the subject "Endometriosis," Dr. Herman C. Pitts described the adenomas of the endometrial type, at the regular meeting of the Friday Night Medical Club. Dr. B. Earl Clarke discussed the pathological features and demonstrated microscopical specimens of the condition. It has been unusually prevalent in this community during the past year.

December 23. The Jacobi Medical Club met at the Miriam Hospital Annex. Professor J. I. Jankelson, of Tufts Medical College, gave the address; his subject, "Differential Diagnosis of More Common Conditions in the Abdomen."

RECENT BOOKS

Urological Roentgenology, a manual for students and practitioners. By Miley B. Wesson, M.D., Ex-President, American Urological Association; and Howard E. Ruggles, M.D., Roentgenologist to University of California Hospital and St. Luke's Hospital, and Clinical Professor of Roentgenology, University of California Medical School. Octavo, 269 pages, with 227 engravings. Cloth, $5.00, net. Philadelphia, Lea and Febiger, 1936.

This is a very fine and useful book. It presents a "bird's-eye view" of urologic surgery from the stand-point of diagnosis; emphasizes possible mistakes in technique and interpretation; and discusses in detail the methods, armamentarium, indications, contra-indications and dangers of the various forms of urologic diagnosis.

As the title indicates, the volume concerns itself mainly with urologic roentgenology, not with treatment. Rarely have we seen such a valuable collection of interesting and characteristic roentgenographs. The pictures are clear, technically excellent, and instructive. The pathology of urology is graphically illustrated in each chapter, every warning given, and every disease described being demonstrated by an accompanying roentgenograph. Indeed, if one were to examine only the x-ray studies, with their accompanying descriptions, and were to ignore the text completely, he would be well rewarded.

We recommend this book to the young urologist, and to the profession at large, but especially to the general surgeon who may desire to improve his understanding of the proper interpretation of pyelograms, cystograms and urethrograms. Here he will find, in compact form, excellent examples of every urologic disease, including such rarely diagnosed conditions as chyluria, and aneurysm of the renal artery.

We suppose that it would be impossible to write a brief text, covering any subject as profound as urological roentgenology without, at times, becoming didactic. This volume is no exception, and at times we wish that we might have either the privilege of a more detailed description, or the opportunity of disagreeing with certain observations and conclusions. For example, in discussing hydronephrosis, we find the statement that the obstruction may be partial or complete, but must be constant "and have existed over a considerable period of time." What is meant by "a considerable period of time"? We have seen hydronephrosis develop within two or three days and believe it may develop in less time than that. And again, "Long continued colon bacillus infection in many cases produces renal mobility and sagging of the kidneys, which is responsible for the obstruction of the urinary flow and the resultant dilatation of the kidney pelvis. A marked ureteritis frequently causes a "pipe stem ureter." We believe that infection per se in most instances produces fixation, rather than mobility; and we are of the firm opinion that the ureteritis, with its accompanying edema, rather than a postulated and unexplained renal mobility, is the true cause of "the obstruction of the urinary flow and the resultant dilatation of the kidney pelvis."

However, in spite of such differences as we may have with certain of the authors' explanations and statements, the main purpose of the book, namely, the presentation of comprehensive roentgenograms illustrative of urological pathology, is more than well done. We have studied their work with pleasure and profit, and we recommend it without reservation.

ROBERT R. BALDRIDGE.

THE 1936 YEAR BOOK OF GENERAL MEDICINE. Edited by George F. Pick, M.D., Lawrason Brown, M.D., George R. Minot, M.D., S.D., F.R.C.P. (Hon.) Edin., William B. Castle, M.D., A.M., M.D. (Hon.) Utrecht, William B. Stroud, M.D., George B. Eusterman, M.D. The Year Book Publishers, Incorporated, 304 South Dearborn Street, Chicago. 1936. pp. 848. Cloth, $3.00.

This annual compact summary of articles written in the preceding year needs no introduction to most practitioners. Its excellence has been demonstrated in the past by the concise manner in which the articles have been abstracted, and by the way in which the essential elements of the original author's work have been maintained. At the end of an article occasionally there appears some comment by one of the Editors who are among the outstanding physicians of the country. These remarks are pithy, and, on the whole, add to the general context. To make the book more readable, the articles are grouped into subjects, such as infectious diseases, diseases of the chest, bronchi, blood, kidney, etc. A note at the foot of the page gives the journal reference in case the original article is to be consulted. Diagrams and photographs are given where needed to amplify the text. There is an adequate index. This book is recommended to those whose interest is particularly in medicine, and who desire to keep up to date. It makes an excellent reference book.

F. H. C.

A TALK TO THOSE ABOUT TO WED. By Addison W. Baird, M.D. Furnished at cost to Physicians, Clergymen, Teachers and Leaders in Social Betterment but not advertised. The Addison Press, 12 East 86th Street, New York. 1936. Pamphlet, pp. 15. Ten cents.

This little pamphlet of 15 pages is presented by a practicing physician after a long and active professional life. Dr. Addison Baird has given a most sane and sensible treatment of this matter. He has pointed out in the first few pages some pitfalls which lie in the way of young people, and has given in the later pages, a direct presentation of the facts of marriage as it seems to me they should be presented by the good physician.

His closing words will show the purpose which underlies the writing of this pamphlet, "Thus I close where I began, with an ardent desire to see worthy young men and young women safely married, with an earnest purpose to make clear what they may expect in the intimate married relation, and with a lively hope that through love and loyalty each couple will enjoy an immeasurable physical, mental and spiritual happiness.

It seems to us that this is a very ethical and proper presentation of the subject.

GEORGE W. WATERMAN.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the December Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the president, Dr. William S. Streker, on Monday, Dec. 7, 1936, at 8:50 P. M. The minutes of the last meeting were read and approved. Their applications having been approved by the Standing Committee, the following were elected to membership:

Giovanni Capobianco
Robert Gordon Murphy
Thomas Patrick Sheridan
Philip Solomon
Arthur Hilton Vaughn

The following obituaries were read: of Edward J. Logan by Dr. Fred A. Coughlin; of William McDonald, Jr., by Dr. Niles Westcott; and of James W. Leech by Dr. Edward S. Brackett. It was voted to spread these on the records and to send copies to the families.

Dr. Halsey DeWolf reported on the work of the Committee on the Advisability of a Plan for the Medical Care of the Low Income Group. It was voted to accept this statement as a preliminary report.

The President announced the appointment of the following Obituary Committees: for the late Dr. Augustus W. Calder—Drs. Albert A. Barrows and William P. Davis; for the late Dr. W. Louis Chapman—Drs. Frank E. McEvoy and Charles E. Hawkes; and for the late Dr. John G. O'Meara—Drs. Richard F. McCoart and Charles A. Gannon.

The first paper of the evening was read by Dr. Vincent J. Oddo and was entitled "Transurethral Resection of the Prostate Gland—A Conservative Evaluation." The speaker advocated a conservative attitude with careful selection of patients and careful pre-operative preparation. He reported the results obtained in 75 cases during the last 6 years; of these 75 patients 12 had malignant disease of the prostate. There was no immediate mortality. Low spinal anaesthesia was used in most cases. He discussed the technic of operation, the post-operative care, and post-operative complications. The paper was discussed by Drs. Kerney, Howard K. Turner and Wm. A. Mahoney.

The second paper of the evening was read by Dr. James P. O'Hare, Assistant Professor of Medicine at Harvard Medical School, and was entitled "Interesting Problems in Hypertension and Bright's Disease." The speaker outlined the history of several unusual and interesting cases coming under his care and observation over a period of years; including a case of glomerulo-nephritis of 20 years' duration, nephrosclerosis, hypertensive encephelopathy, nephrosis, and vascular hypertension in a young woman of 24 who went through normal pregnancy without disaster or progression of the disease. Dr. O'Hare discussed various aspects of disease illustrated by these cases, commenting on unusual or striking features in a very interesting and enlightening manner. The paper was discussed by Drs. Wells and Burgess.

The meeting adjourned at 10:45 P. M. Attendance 137. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, *Secretary.*

PUNCTUALITY

It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

—From the Code of Ethics of the A. M. A.

OBITUARY

DR. WILLIAM McDONALD

On August 1, 1936, there died at Marion, Mass., after a long illness, William McDonald, Jr., M.D., scientist, philosopher and physician. Born in Albany, N. Y., June 2, 1873, he studied in Albany schools, Brown University (class of 1895), College of Physicians and Surgeons of Columbia University, receiving a Diploma in Medicine and a Master's Degree in Arts in the same year, 1899. He was interne at the Rhode Island Hospital, 1899-1901; resident and later Clinical Director at Butler Hospital, 1901 to 1909. At this time, 1909, he entered the practice of neurology and psychiatry in Providence. He was Visiting Neurologist to the Rhode Island Hospital and to the Memorial Hospital, Pawtucket. Following the explosion at Halifax he organized the neurological clinic for the victims of that disaster. He later was commissioned Captain in the U. S. Army and was overseas serving with the 1st, 2nd and 3rd Armies. He was credited with two battle stars, returning with a commission as Major, M. C. In 1919 he was assigned command of the Neurological and Psychiatric Division at the Walter Reed Hospital in Washington. Later in the same year he was discharged and placed on inactive duty as Senior Surgeon, Public Health Service.

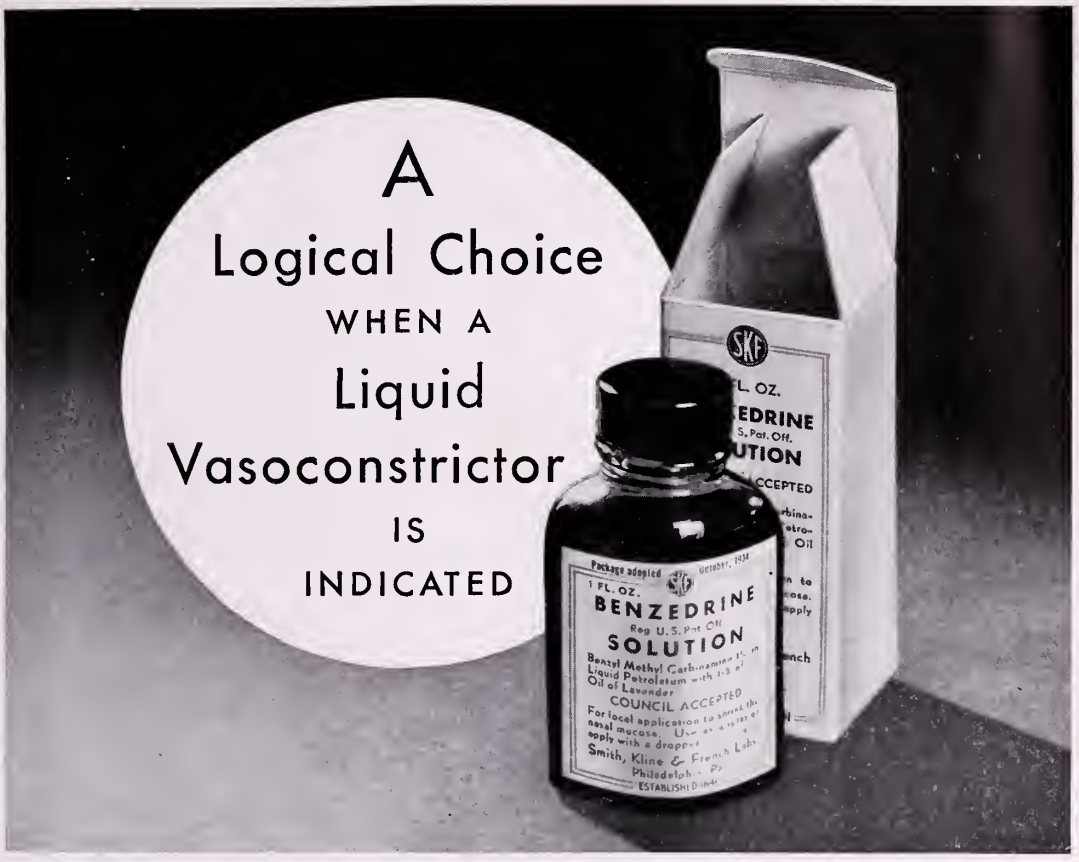
In 1919-20 he made a survey of nervous and mental diseases in North Carolina under the auspices of the National Committee for Mental Hygiene. In 1920 and 1921 he lectured on neurology at the School of Medicine, Yale University, and was Visiting Neurologist at the New Haven Hospital.

In 1921 he practically gave up active practice, failing health and eyesight forcing him to limit his work. A brilliant, thorough worker in whose plans time was of little account, he gave his attention as best he could to a few selected cases, particularly those with the neurological problems following anterior poliomyelitis and encephalitis. Four years ago physical handicaps became too great for him to carry on and at length none of his dearest friends could wish him a continuation of his misery.

He married, February 18, 1909, Elizabeth Merchand Hurkamp of Fredericksburg, Virginia, who died two years ago following a long, painful illness. There are no children.

Dr. McDonald contributed numerous carefully prepared articles to the literature of medicine, particularly to the American Journal of Insanity and our own Medical Journal. He made thorough studies of general paresis, the psychoneuroses, paranoia, the symptomatology of brain tumors and the particulars of aphasia. His work is a monument of careful search for facts and accurate deduction. It is hoped that a detailed study of his work may be made and presented to us.

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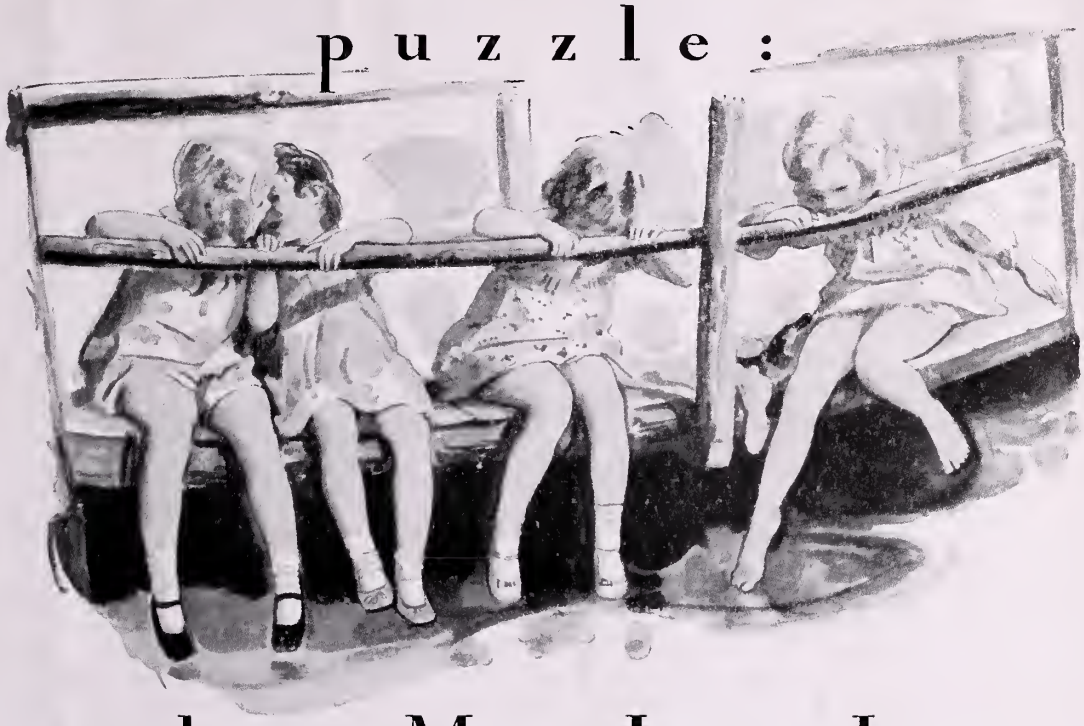
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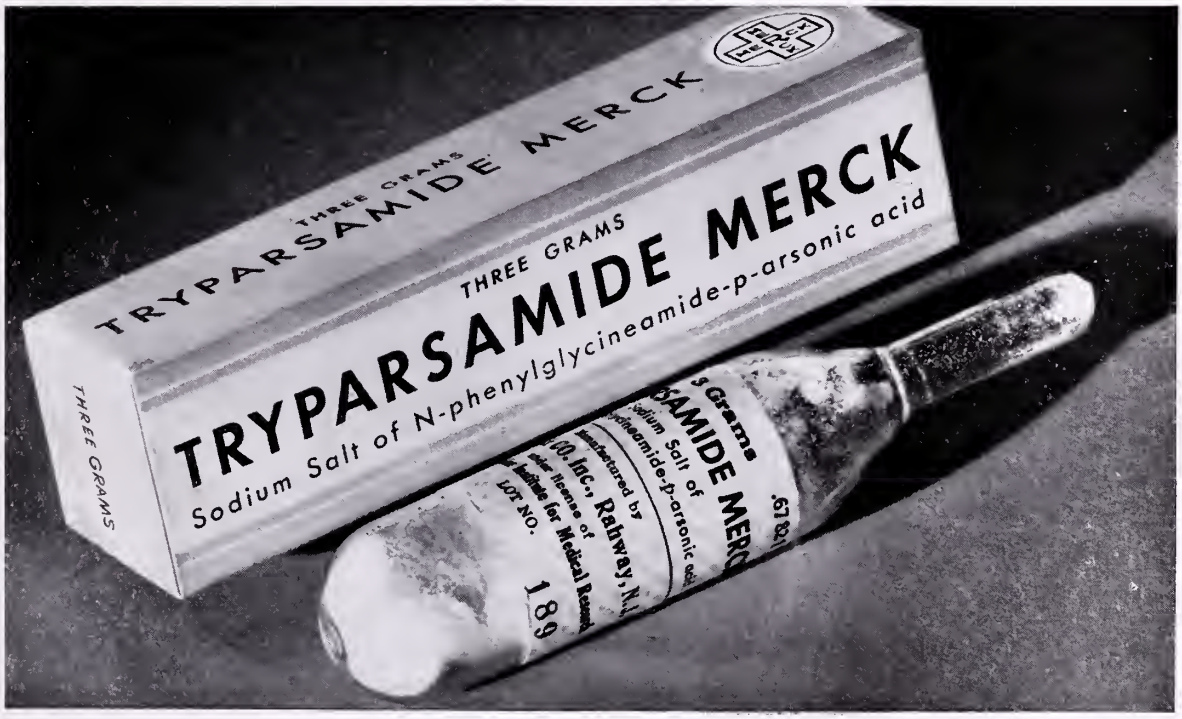
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THE N.Y. ACADEMY OF MEDICINE
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The Role of House Dust in Bronchial Asthma, by Dr. William P. Buffum

A List of the Officers, Committees and Fellows of the Rhode Island Medical Society

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It has been shown that spinach slowly loses its vitamin C potency even in low temperature storage; at room temperature, one-half of the vitamin C is lost in three days; practically all antiscorbutic potency disappears in seven days (1).

Another report indicates a loss in vitamin C of 78 per cent in spinach stored two days at room temperature and 80 per cent loss in asparagus tips during four days' storage (2).

The vitamin C content of apples is markedly reduced during cold storage: 20 per cent in 4 to 6 months and about 40 per cent in 8 to 10 months (3).

Vitamin A in apples is, however, subject to less destruction than vitamin C during prolonged storage (4).

Prolonged cold storage of pears may result in a loss in the vitamin A and vitamin C content of nearly 50 per cent (5).

Further, solution losses which may occur during cooking vary with the individual product and with the method used in cooking. From 40 to 48 per cent of vitamin C may be lost to the water in which peas are cooked (6).

Vitamin C losses in 12 different vegetables have been reported to vary from 12 per cent in asparagus to 80 per cent in white onions (7).

These data demonstrate the seriousness of solution losses of vitamin C. It is considered probable that other water soluble vitamins are affected in a similar way.

Thus, by the time fruits and vegetables spend some days in transit or storage before reaching the kitchen and are cooked by the usual home method, much of the original vitamin content may have been lost. Little can be done to prevent storage losses when fresh fruits and vegetables are not available from the home garden, but solution losses may in part be overcome by using the cooking water.

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(1) 1936. Food Research 1, 1.
(2) 1936. J. Soc. Chem. Ind. 55, 153T.
(3) 1933. J. Agr. Res. 46, 1039.
(4) 1936. Food Research 1, 121.
(5) 1934. J. Am. Diet. Assn. 10, 217.
(6) 1936. J. Nutrition 12, 285.
(7) 1936. J. Home Econ. 28, 15.
(8) a. 1921. Proc. Soc. Exp. Biol. Med. 18, 164
b. 1928. Ind. Eng. Chem. 20, 202
c. 1929. Ibid. 21, 347
d. 1932. J. Home Econ. 24, 826

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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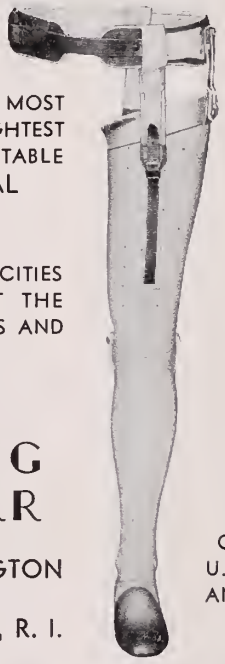
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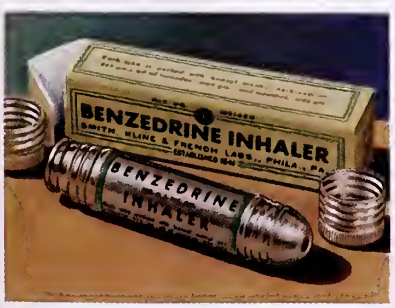
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CASE HISTORY: T. A. Male, white, age 27. Acute exacerbation of a chronic sinus infection.

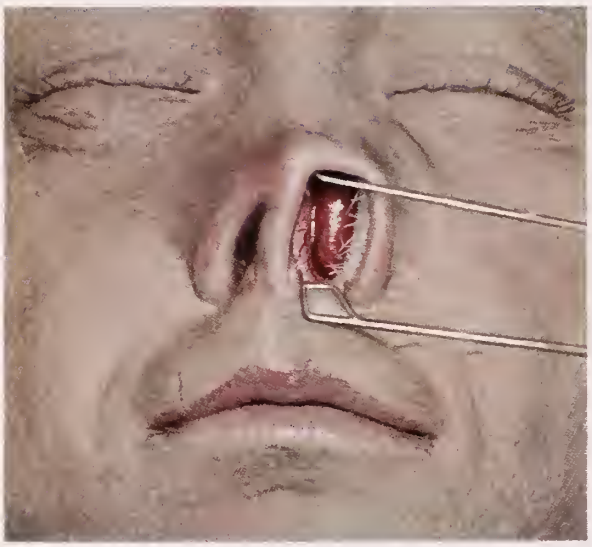


FIG. 1. 2:35 P.M. Before treatment.

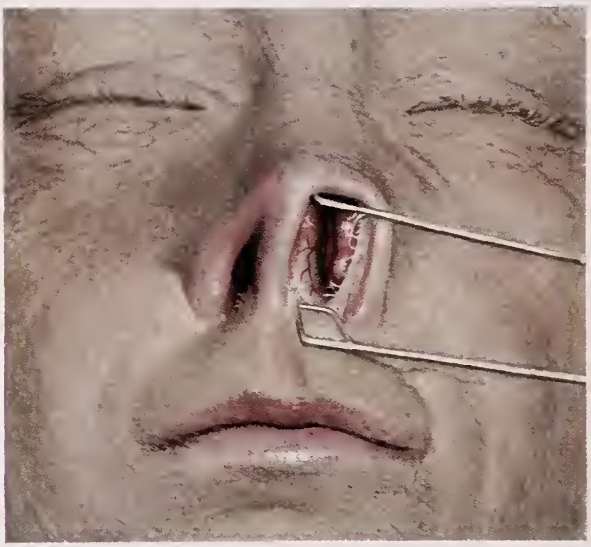


FIG. 2. 2:57 P.M. After using Benzedrine Inhaler. Drainage established.

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Karo	2 tablespoons
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Karo	2 tablespoons

References: Kugelmass, Clinical Nutrition in Infancy and Childhood, Lippincott; Marriott, Infant Nutrition, Mosby; McClean & Fales, Scientific Feeding in Infancy, Lea & Febiger.

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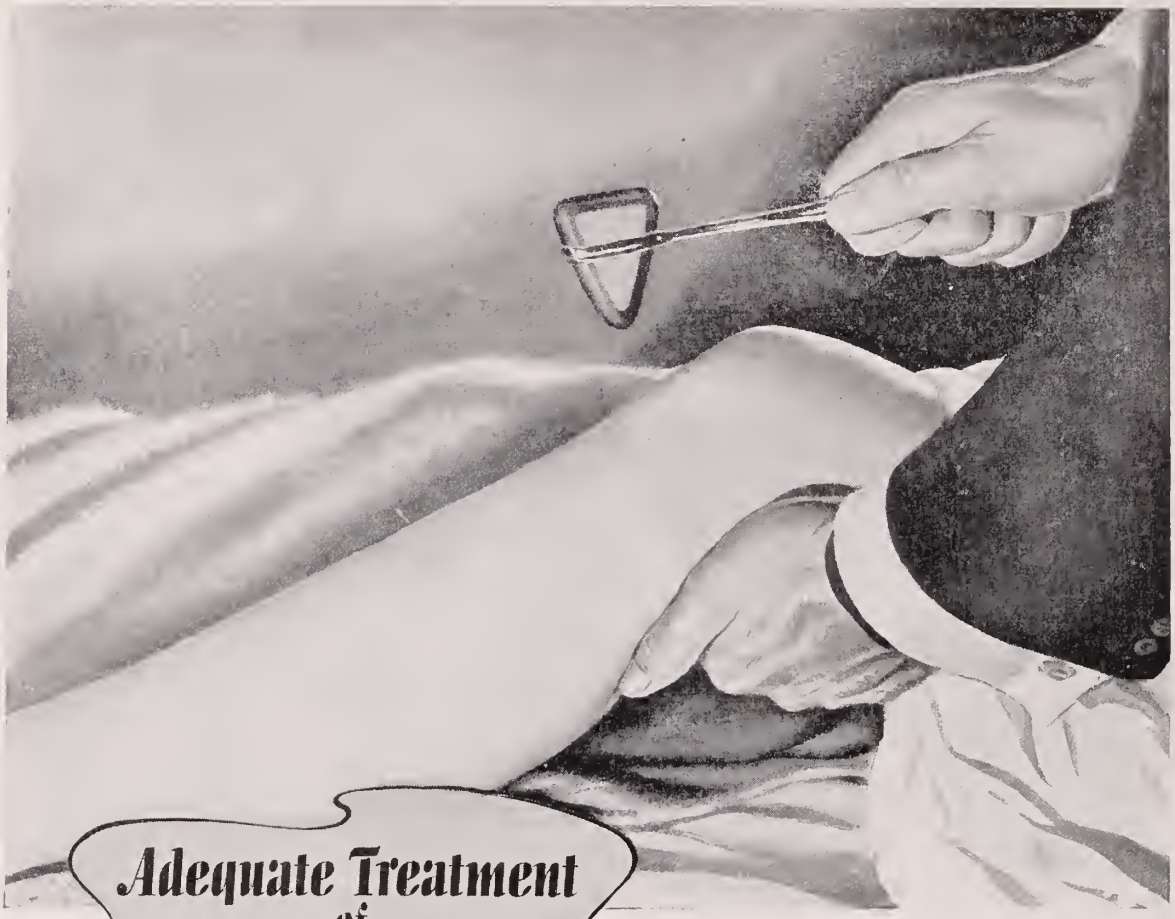
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The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

VOLUME XX
NUMBER 2
Whole No. 329
PROVIDENCE, R. I., FEBRUARY, 1937
PER YEAR $2.00
SINGLE COPY 25 CENTS

ANNUAL ADDRESS OF THE RETIRING PRESIDENT OF THE PROVIDENCE MEDICAL ASSOCIATION

WILLIAM S. STREKER, M.D.
179 ELMWOOD AVENUE, PROVIDENCE, R. I.

My first impression of the Providence Medical Association was received a quarter of a century ago from one whom I then considered an old physician but whom I would now classify as middle aged. In expounding the benefits of membership he informed me that the papers were fine—to say nothing of the excellent lunches which alone were well worth the dues. I made my application forthwith. I trust that today no members, or prospective members, have any such inadequate impression of the functions of our society. It is somewhat difficult for me to resist the temptation to review the outstanding changes in medical service during those twenty-five years; but I fear that such a recital would be of but mild interest to the younger members and would probably bore the older ones. So, in better keeping with the spirit of the by-laws of the Association, I shall attempt to look ahead in addressing you this evening. Occasionally it may be permissible to glance in the rear vision mirror. The man on the motorcycle may have a message which, no matter how unpleasant, we must heed. Our principal concern, however, must be with the signals ahead, even though they be conflicting, confusing and difficult of interpretation; for that is the direction in which we wish to travel.

In these days we hear much of the changing social order; and it is beyond question that a profound change is taking place. Medical organization is an essential part of the general social scheme and so medical practice must be adjusted to the changes in the social order. Some of this adjustment has occurred so subtly that we have hardly realized the fact of its presence. What is to be our attitude towards future developments? Shall we adopt a passive attitude of "wait and see" and then accept, or attempt to reject what is offered? Or shall we take an active part in shaping and developing changes which concern the problem of rendering good medical service to the public and obtaining proper remuneration.

Let us descend to particulars. Is it not reasonable to infer that much free hospital and clinic work is at the expense of private practice in patients' homes and doctors' offices? This situation we have encouraged because the hospital and clinic organizations, equipment and personnel help us so much in the care of patients. Individuals and families soon become "clinic-minded" when they learn how much they can procure by way of diagnosis and treatment with little or no cost to themselves. Since the physician donates his services to this large group, should he not be strongly represented in the organizations which formulate rules and criteria governing the acceptance of patients who are to receive his gratuitous services? His county medical society can best furnish this representation.

To treat the poor without thought of payment is the most inspiring part of the doctor's work and is one of the ideals inherent in the fundamental structure of the practice of medicine. However, all who find themselves unable to pay for medical care are not necessarily poor. No longer is it a matter of remark that an individual drives to the free clinic in his own car. Many find themselves unable to pay for adequate medical service, not because they have so little but because they have obligated themselves to pay for so many things which they have, humanly enough, placed before provision for the expense of possible illness. Whether we favor this present-day trend or not is beside the question; our problem is to adjust ourselves to existing conditions.

This Association was incorporated "for the advancement of sound medical science and the promotion of the character, interests and honor of the medical fraternity." The aims remain unchanged but the scope of activity has widened greatly. Cooperation is called for with the state and national organizations, public health departments of city and state and numerous official and voluntary health agencies of various kinds. The proper functions of the county society include encouragement and extension of preventive medicine in private practice, supervision of the quality of medical service includ-

Delivered at the Ninety-first Annual Meeting, Providence, January 4, 1937.

ing proper listing of specialists, the fostering of postgraduate work. Plans for the care of the indigent should be studied. A committee is already struggling with the question of a plan for the medical care of the low-income group. Some county societies have successfully provided facilities for post payment projects. Others have established their own credit and collection bureaus in order to avoid the victimization of physicians by unscrupulous collectors and unsound credit and collection schemes. The abuses of industrial contract practice and lodge work should be corrected. These thorns in the side could and should be removed. Education of the public in medical matters should be further encouraged. Proper interest and participation should be maintained in all legislation dealing with medical and health affairs, with a militant stand against quackery and the cults.

I have tried to call your attention to some of the complex problems with which we are confronted. Are we properly equipped to meet them? The officers and members of committees have given unstintingly of their time and energy and have done all that could be done with our present set-up. No group of practicing physicians can donate sufficient time and effort to make the contacts and do the executive and secretarial work required of a modern businesslike county society. The employment of a full-time, well qualified executive secretary, working under the direction of our officers and assisting them and the various committees in the work that lies before us, would be a long step in the right direction. An aggressive constructive program is our best answer to the threat of state medicine.

I trust that my remarks will not be construed as trespassing on the prerogatives of your newly elected officers. Think of them rather as an attempt to stimulate the interest and elicit the support needed for the successful administration of your society's affairs, including the many medico-economic problems of our present-day complicated social structure.

A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

—*From the Code of Ethics of the A. M. A.*

AMENITIES OF THE OPERATING ROOM*

Dorothea V. Phelps, R.N.

The operating room is one department of the hospital in which the patient surrenders many of those rights of which he is in active possession when conscious. The fear of losing consciousness, the anxiety, uncertainty, and dread which beset the individual about to be anesthetized for an operation cannot be realized by one who has never experienced this approach to abject submission. The patient feels that the operation is a major crisis in his life, as it may well be. Absolute faith, a good measure of confidence, and courage are genuine requisites in such an emergency. All who share in the responsibility for the action which takes place when the patient is entirely oblivious to his surroundings should realize that in their hands rests the life of a human being, a trust than which there is no other more noble or exalted. Consequently, it seems appropriate to call attention to some important factors bearing upon the patient's welfare and security in the operating room.

The operating-room supervisor, sterile and unsterile nurses should be individuals of experience ready to apply promptly the sort of help required in any situation. Yet with all this preparation the patient may not receive the last morsel of attention to which he is entitled. Why? Because the amenities of the operating room which play a great part in broadening the margin of safety in surgery are sometimes neglected. These amenities lessen confusion, save time, and give assurance to patient and to surgeon. They result from two cardinal virtues, foresight and teamwork, and their value to patient and personnel cannot be too highly stressed.

Alertness and foresight on the part of the supervisor and careful training of her assistants will create a spirit of co-operation within the group and prevent unnecessary friction and disconcerting hurried exits for needed supplies. Thoughtfulness and courtesy will redound to the benefit of the patient in countless ways. In shaving the field of operation, many painful abrasions can be avoided if the nurse remembers that the surgeon makes the initial incision. If the patient's skin is sensitive, strong antiseptic solutions ought to be used with discrimination and care. Strong iodine is often re-

*Abstracted, by permission, from the *Bulletin of the Truesdale Hospital and Earle P. Charlton Surgery*, 10, 2, March, 1936.

sponsible for painful burns especially when the solution is allowed to drain into the folds of the groin and breast.

Some amenities when in evidence are felt by the patient as soon as she enters the operating suite. They ameliorate her mental and physical suffering, dispel the fear of impending death, and awaken confidence and hope. They also shield her from unnecessary noise, alarming professional comments, obnoxious odors, distressing sights, rough handling, and inexcusable delay in the etherizing room.

The care of the patient does not end here. Adjustment on the operating table is carefully supervised in order to limit exposure and protect the elbow, shoulder, hip, and knee joints. Experimentation with devices and supports to add to the comfort of the patient and provide a better approach for the surgeon is encouraged. The padding of metal shoulder supports is likewise inspected frequently to avoid pressure on the brachial plexus. Tourniquets when applied should not be thoughtlessly left in place too long. The temperature and quality of air in the operating room are of vital importance to patient and operating-room force. Elderly patients and the very young should not be exposed to a temperature of less than 85 degrees F.

Since the surgeon and his assistants are busy with the intricacies of the operation, many minor matters, which may assume major import, become the duty of the supervisor to correct by action or suggestion. Adequate illumination of the immediate field of operation and absence of glare, direct or reflected, are indispensable, but the surgeon may be too preoccupied to scrutinize the lighting to see if the converging rays illuminate effectively the depths of the operative field.

After the operation is completed, the patient is gently lifted to the stretcher and well covered before leaving the warm operating room. She is thus protected from draughts of air in the hospital corridors and taken quickly to her room. Two persons attend the stretcher and there is adequate assistance when the patient is lifted from the stretcher to the bed.

Such thoughts as those expressed above, no doubt, frequently occur to surgeons and nurses in operating rooms the world over. This solicitude explains the high degree of conscientiousness in this department, which is always apparent to the trained observer.

THE ROLE OF HOUSE DUST IN BRONCHIAL ASTHMA

WILLIAM P. BUFFUM, M.D.

122 WATERMAN STREET, PROVIDENCE, R. I.

There is a great difference in opinion as to the importance of house dust as a cause of asthma. O'Keefe[1] says, "House dust was frequently found positive. Its clinical significance is difficult to determine." Bowman and Walzer[2] state, "Few atopens are so widely used and give so many positive reactions as house dust. In spite of this fact, the nature of the active principle contained in dust and the significance of the reactions obtained with it are still subject to debate." Rowe[3] concludes that, "Dust reactions may depend on one substance, or on a summation of lesser reactions to several substances, such as animal emanations, orris root, pollens, and various fabric dusts, and that the possibility of an unknown specific substance in house dust is unlikely." Rackemann[4] says, "Among the domestic dusts, the animal emanations probably rank first as a cause of asthma. Next in importance come the house dusts." Cooke[5] writes of the causes of asthma, "The principal airborne substances rank as follows in the ninety-four cases (up to 15 years of age): house dust, 55 cases; ragweed, 21 cases; feather, 19 cases; . . . "

House dust as an exciting cause of bronchial asthma was noted by Cooke[6] in 1922. With VanderVeer, he described in several articles this allergen and its occurrence. The active principle is found in the dust of dwelling houses, but not in the dust of public halls or other places where people do not live. It is a specific allergen, occurring with no other known allergen in many potent house dusts, and probably is identical in all cases. Cooke prepared the so-called New York Hospital Extract from the dust of a New York apartment house. This extract gave approximately the same number of positive reactions to patients in the United States, Canada, Europe and Australia. However, house dusts frequently contain such other known allergens as cattle hair, chicken feathers, orris root and

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Read before the Providence Medical Association, at the meeting of October 5, 1936.

Thanks of the author are due to Dr. Gordon J. McCurdy for supervising the Rhinology in the clinic, to Dr. Stanley S. Freedman for his careful and skillful testing, and to Miss Marian Baker and others of the Social Service department of the Rhode Island Hospital for the follow-up work which made possible this review of cases.

probably other active substances which have not yet been recognized.

Cohen, Nelson and Reinarz[7] state that, "A patient who reacts with symptoms only on exposure to dust, and gives skin tests and passive transfer tests to it and to it alone, will react similarly clinically and by test to other samples of dust collected from a variety of sources. For example, a patient from Holland, sensitive to house dust alone, reacts to samples of dust collected in Cleveland, Ohio; Tampa, Fla.; Little Rock, Ark.; and to dust from her own home in Holland." They have also shown in very carefully controlled experiments that an allergen develops in cotton linters kept under aseptic precautions for 8 months. Apparently they have proved that the allergen develops in the cotton linters, and that molds, bacteria or contamination with other allergens play no part in this development. They have shown that this allergen is identical with that commonly found in house dust, and suggest as probable that this allergen also develops in such other substances as kapok and feathers.

It is a common observation that when asthma patients enter a hospital symptoms are likely to disappear. This improvement is much more frequent and striking than is caused by other change in residence. In moving from home to a hospital one may escape from many inhalants, but the obvious one is dust from the bedding, rugs and stuffed furniture. As no definite connection has been demonstrated between sensitivity to house dust and the improvement at the hospital, this argument should not be given too much weight.

Description of Cases

The observations in this paper are based on 64 patients with bronchial asthma who were treated in the Pediatric Out-Patient Department of the Rhode Island Hospital and in whom treatment was started between January 1, 1932, and September 1, 1935. Eight patients were left out of the series because they had paid less than four visits to the hospital or because they had moved and could not be traced, otherwise the 64 patients were consecutive.

History

In searching for the exciting cause in a case of asthma, the history is of the first importance and this is often a more useful and more reliable guide than the skin test. A specific diagnosis is made from the history, the skin test, and the effect of adding the suspected substance to the environment or removing it therefrom.

A patient who is having his symptoms chiefly or entirely as a reaction to house dust would give a history consistent with this. He would probably be about the same all the year round, and would be likely to have some wheezing frequently, possibly every day. He might have such incidents as increased trouble on days of house cleaning, or on days in which he plays or works around the house. He would be expected to get marked relief on moving to an institution, or to a house where the rugs, stuffed furniture and old pillows and mattresses had been discarded or cleaned and covered. A history of the wheezing occurring at long intervals, or only with colds, or being much worse at certain seasons of the year, or with marked difference at different localities or in different houses, would make it less likely that house dust is the principal factor.

The Skin Test

Positive skin tests by no means show that the patient is clinically sensitive to the substances used. Many strongly positive tests which do not correspond with any clinical symptoms are obtained. If slightly positive tests are included, it would seem that most positive tests are unrelated to the cause of the attacks. Many children give positive tests to foods and yet in very few is a food the cause of the asthmatic attacks. Recently several observers have obtained positive tests in about 50% of normal persons. Many of these reactions are apparently due to an allergic response which is not paralleled by any clinical manifestations; some of the lesser reactions are due to an irritation which is not allergic. Allergists do not consider that a positive test is a definite sign of allergic hypersensitiveness unless it can be transferred by the indirect method.

Skin testing with house dust has been done in many clinics. The percentage of positive reactions has varied from 33% to 96%.[8] This wide difference in results is almost surely due to differences in technic, in preparation of testing material, or in interpretation of results. As Walzer has pointed out in a recent communication,[9] house dust is an irritating substance which gives many skin reactions in both allergic and non-allergic individuals. It would seem, however, that a definitely positive reaction which fits in with the clinical history and course of the disease is of considerable value.

Cooke used his preparation intracutaneously. While most allergists still use a similar procedure,

some of the best men prefer the scratch test. The scratch test is much less sensitive, which is not always a disadvantage, and also takes a less elaborate equipment.

In this group of cases all were tested by the scratch test, using a commercial preparation; many were also tested intracutaneously with a stock extract, and frequently various dusts from their own homes were used. A test was considered positive when the reaction was definitely larger than the controls. With the house dust testing, slight positives were not considered significant as the testing substance is often irritating. Of this group 45% gave a positive test to house dust and 36% gave at least a two plus test. The percentages of positive reactions with the other antigens were pollen, 45%; animals, 19%; foods, 36%; other inhalants, 16%. All tests were negative in 19%.

General Treatment

In general the treatment was of the usual type. Efforts were made to correct anemia and malnutrition. Tonsillectomy was done occasionally. Rhinologic treatment consisted chiefly of nose drops; a few cases had ionization of the nose, and a very few had antrum drainage. For the attacks, ephedrine capsules, 1-100 adrenalin spray, and burning stramonium leaves were the principal remedies; a few severe attacks required admission to the wards.

Where animal emanations seemed a possible cause, efforts were made to avoid animals and materials which might contain their emanations. Pollen asthma was treated chiefly by desensitization. Foods which seemed to be a cause of trouble were left out of the diet and any food which gave a positive skin test was avoided as far as possible.

Vaccines were used a good deal: in fact most of the patients, except for those who were receiving some specific antigen, were given vaccines periodically until their symptoms were relieved. In a few cases an autogenous vaccine was made from the discharge from an antrum, otherwise a commercial mixed catarrhal vaccine was used.

The Crawford Allen Memorial Hospital, the convalescent department of the Rhode Island Hospital, was of great service to a few children with malnutrition associated with mild asthma.

Specific House Dust Treatment

The specific treatment of house dust sensitivity was an attempt to eliminate house dust. Most of the patients were given a typed list of house dust instructions. In the cases where house dust was a suspected cause, one or more house visits were made by a social service worker to see that they were carried out. In some cases the instructions were carried out very well indeed, but in more cases the dust elimination was unsatisfactory or entirely worthless. Usually, however, when it was felt that house dust was an important cause of attacks, we were able to get good co-operation.

The instructions included the elimination from the house of carpets, rugs, unwashable hangings and stuffed furniture. Small washable rugs only were allowed and the floors were to be kept clean by washing, and dusting with a wet mop. The bedroom was to be kept as bare as possible. The bedding was to be kept clean by washing and no unwashed blankets or quilts were to be used. As these people could not buy new pillows, mattresses or the commercial allergen proof covers, they used thin hard pillows and mattresses, as new and clean as possible and covered tightly with oil cloth.

Desensitization to house dust was not used on this group.

Results

Sometimes it is certain which allergen is causing the attacks, in some cases it is probable and in others it is just guess work. Instead of taking up your time with details of tests and attempted grouping of cases, I shall mention a few details about individual patients and then give results on the whole group.

Patient No. 4 gave a history of occasional mild attacks usually on Sunday. She gave positive tests to the commercial house dust preparation and a very large test to her own house dust. No other tests were positive except a faint one to sweet potato which was known to give gastrointestinal symptoms. Nine months ago her house was cleaned according to the house dust technic and the stuffed furniture was removed. She was then ill for 24 hours with a profuse urticaria and since has had no asthma.

Patient No. 2 came to the Out-Patient Department in 1928 at six years of age. Since infancy he had severe asthma. In 1933 a note was made that he was having some wheezing every night and severe attacks kept him out of school about half the time. His skin tests were positive to house dust and ragweed. From 1928 to 1934 all treatment failed to give any relief. In 1934 his house was cleaned up and now he is almost well; during the last year he

has had four or five slight attacks but was not out of school on account of asthma.

Several other cases were nearly as dramatic as these. One boy always had his attacks on Saturday night after the house had been swept. Another child was given an intracutaneous house dust test in the morning and that night had a very bad asthmatic attack accompanied by much swelling and pain in the arm in the region of the test.

In summarizing the results I have classified the cases in 4 groups as follows:

1. No symptoms for one year.

2. Much improved. These patients may have had one attack during the year or several very mild attacks; they live normal lives and are as well and happy as the average healthy child.

3. Improved. These children are definitely and markedly better than before treatment. The attacks are much less frequent or are of a milder character or both.

4. Unimproved.

No other groups were necessary as none of these children are worse or have died.

Twelve children that seemed most clearly to be suffering from house dust sensitivity, had on the average more severe asthma than the other patients; two of the group were the worst cases of all and were well known in the Rhode Island Hospital wards. One has had no attack for a year, and the eleven others are classified as much improved. Two have gone nine months without an attack; one has had a slight attack during the last year. The two that have the most trouble now have had several attacks but these have been very mild and have not kept them out of school.

The results of the whole 64 cases may be classified as follows:

1. 18.8% have had no symptoms for a year or more.

2. 43.8% are much improved, that is are almost entirely relieved. These two groups together make 62.6% of the total.

3. 31.2% more are improved.

4. 6.2% are unimproved.

In commenting on these results, I should say that the 18.8% entirely relieved for a year is too small a number to be satisfactory. This is due chiefly to two factors; first, many of the cases had been under observation for a comparatively short time when the year began; second, in the out-patient department it is very difficult to do sufficiently intensive detective work. On the other hand, the relief given has been very great: the 62.6% complete or nearly complete relief is a good figure and the total of 93.8% that have been given definite help is better than would be expected. Obviously, however, too much emphasis should not be laid on statistics based on such a very small number of cases.

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Discussion

Dr. Chafee: The subject of allergy is a confusing one, what with the ever increasing number of allergens that are being found. For instance, Biederman, in the Journal of the A. M. A. of June 27, 1936, presents a case in which the patient had a dermatitis venenata of the hands and feet from the fumes of gasoline in the truck in which he was riding.

House dust contains many substances which to the uninitiated should appear to cause reactions. The experiment in which the Dutchman reacted to the New York apartment house dust is interesting but what with the numerous other allergens such as kapok, animal hair, etc., I do not see why they should not have some consideration. I should like to ask Dr. Buffum if any experiments have been done with house dust in which cotton linters are absent.

We all know that the patient with asthma does better with hospitalization. In some hospitals where an oxygen room is available, patients are placed in this room and provided with plain filtered air. It has been found that they "snap" out of their asthma more quickly with this procedure. Another experiment that has been tried by Barach in New York is giving these patients a mixture of helium, 80% and oxygen, 20%. I do not know the result of his experiment other than it eases the work of pulmonary ventilation.

Dr. Buffum: Dr. Cohen and his co-workers say that they expect to get the house dust allergen from old kapok and from old feathers. As far as I know this has not yet been proved.

Helium and oxygen seem to be of value in very severe cases and in status asthmaticus. This mixture, because it is more diffusible than air, gets into the lungs more easily, lessens the negative pressure in the bronchi, and decreases the edema and exudation. It is said to be life saving in these cases.

Dr. Riley spoke of the value of change of residence. This is well worth trying, especially with patients that are not doing well or in whom the cause of symptoms cannot be determined.

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ALPHEUS C. MORSE

No ordinary structure could satisfy the vision of the founders of the Rhode Island Hospital. The City of Providence had donated an ideal site, twenty-two acres, close to the city, on an elevation seventy feet above sea level, overlooking the bay. The call for subscribers to the building fund had brought out a generous response, remarkable for the time, harassed by Civil War. The next requirement was for "buildings which should be in every way practical for the work of a hospital; adequately ventilated, heated and lighted; with solid foundations; stairways of stone, fireproof; with a sufficient supply of fresh water to be stored in water towers; a plant capable of expansion to meet the demands of future growth; and withal, buildings in harmony with their setting and not lacking in the element of beauty." This was the task entrusted to a twenty-seven-year-old architect, who had designed private mansions of such dignity and grace as to leave a lasting imprint on the architecture of the city.

Alpheus Cary Morse, son of Hazen and Lucy (Cary) Morse, was born in Boston, June 3, 1818. On April 24, 1855, he married Caroline Emily, daughter of Earl Douglas and Lydia (Wheaton) Pearce. They lived at 44 Benefit Street, Providence, and had three daughters: Ann Goddard; Caroline, married Robert Lane Keach; and Isabel, married Rowland G. Keach. Alpheus C. Morse studied first with Alexander Parrish in Boston and later with Washington Allston in Rome. Following John Ruskin, he studied the architecture of Modena, Pavia, Mantua and Verona. Thence he became a master of the Italian Gothic style, commended by Ruskin "not merely because it is lovely, but because it is the only form of faithful, strong, enduring, and honorable building, in such materials as come daily to our hands." While in Europe, Morse gave much time to painting and crayon portraiture, which occupied him in later years. He gave earnest attention to building materials; stone, brick, cement, studying with his microscope different varieties of wood, learning their intimate structure and their fitness for the purpose of his designs.

For the Rhode Island Hospital, Morse planned a central or administration building, with pavilions or wings; the administration building of sufficient size to provide for the needs of generations to come, the pavilion plan allowing for expansion to an indefinite limit by the simple addition of other wings essentially similar to those first constructed. On massive stone foundations he built brick walls of great thickness, enclosing an air space to protect the interior against changes in temperature; the roof gabled, with a sufficient number of superimposed pinnacles to answer the requirements of a pure Gothic style. The difficult water tower problem he solved by building two towers that fulfil Ruskin's requirements of "characters common to all noble towers, that they rise from massy foundations to lighter summits, more pierced and thinner in wall than beneath, with shadowy niche and buttressed pier, and fearless height of subtle pinnacle and crested tower, sent like 'an unperplexed question up to Heaven.'" The water capacity of each tower was 8,000 gallons. In back of the north pavilion he sunk a cistern for 80,000 gallons reserve supply.

Pure air, heated by passing over steam pipes in the basement, was distributed evenly to all parts of the structure. Within the walls, channels a foot square, of cement as hard and polished as glass, provided a perfect system for ventilation. The buildings faced the East; the wings running north and south, gained the advantage of morning and evening sunlight.

When the Rhode Island Hospital was dedicated, on October 1, 1868, some criticism was heard. The money was all spent yet the north pavilion had not been completed. But Alpheus C. Morse, turning as he left by the Eddy Street gate, saw the massive foundations of Westerly granite, the stairways of close blue stone, the strong timbers of seasoned oak, the efficient heating system, the perfect sewage system, the polished ventilating channels within the sturdy brick walls, the lofty towers crowning all. "I am content," he was overheard to say.

A. H. M.

John Ruskin: The Stones of Venice, 2, 6, 77; 2, 7, 47.

CONTROL OF CERTAIN DISEASES

With the national government lending its resources to the movement for the stamping out of the venereal peril in the United States, it is reasonable to believe that something definite will be accomplished. Since the governments in the Scandinavian countries were so successful in their efforts in the same line, we can look forward to equal results in the United States. The task is not an impossible one when we stop to consider that the tuberculosis problem was taken up by privately formed associations, the interest of the public enlisted, and a marked decrease in the death rate was in this way brought about. In the case of syphilis, where there is now a successful treatment, better results can be produced more promptly. The first essential is the hearty cooperation of the family doctor to seek out the source of the individual infection, and stamp that out as well as treat his patient. Free treatment, both as to material and professional services, has been established indirectly by the United States Public Health Service in over 1000 cities. This department is particularly anxious that this service be given only to the needy and that private practice remain as it is, with the physician cooperating in the national movement.

When authorities estimate that there are more than 400,000 new cases each year, and it is believed 40% of these cases are contracted innocently, the menace becomes a public one that cannot be ignored. Health Departments of the State of Rhode Island are more than anxious to assist the individual physician, and with his interest aroused, we can look forward to a record that will justify the effort.

E. V. M.

FORCED GRASPING IN MAN AND ITS LOCALIZING SIGNIFICANCE

Although the symptom, forced grasping, has been reported in the clinical literature since 1903, it was not until 1932 that the condition was clearly demonstrated in the laboratory. In the last two years data have rapidly accumulated in regard to this sign. We now believe that forced grasping is the result of a dysfunction of the premotor area of the brain, an area histologically differentiated by Campbell of Cambridge University in 1905. When a lesion of this area is produced in animals or occurs in man, it gives rise to a series of symptoms and signs, which have been designated as the "syndrome of the premotor cortex." In addition to forced grasping there is some increase in the tendon reflexes, moderate spasticity of the extremity, associated with awkwardness and sometimes paresis. On the same side there is often an extensor Babinski response. One of the chief features of the syndrome is the loss of the ability to carry out complex skilled movements. This, combined with forced grasping, a reflex which varies with posture and is definitely part of the righting reflex mechanism of the body, are signs which are unmistakable when they occur in man and therefore are of considerable localizing significance. The observation of this syndrome has recently led to the localization of a brain tumor in more than one patient. The syndrome is described and the chief references to the literature given in two papers recently published.

C. A. McD.

MEMORABILIA

[L. neut. pl. of memorabilis, worthy to be remembered or noted.]

December 29, 30, 31, 1936. The American Historical Association held its Fifty-First Annual Meeting at the Providence Biltmore Hotel and Brown University. Ten historical societies met concurrently; including the Mediaeval Academy of America, the History of Science Society, and the American Catholic Historical Association. Physicians were especially interested in "A New Bibliography of Joseph Priestley, with Notes on His Scientific Writings," by John F. Fulton of Yale University; "John Howard and the Public Health Movement," by Leona Baumgartner of New York Hospital; "Reverend Thomas Thacher's 'A Brief Rule' (1677-78), the First Medical Document Published in this Country," by Henry R. Viets of Boston; "The History and Work of the Army Medical Library," by Major Edgar E. Hume of Carlisle Barracks, Penn.; and "Bartolomeo Montagnana's Consilia (1476)," by Dr. Arnold C. Klebs of Nyon, Switzerland. Professor Chauncey D. Leake of the University of California, President of the History of Science Society, presided at its sessions.

January 12, 1937. At the meeting of the Amos Throop Medical Club, entertained by Dr. N. Dar-

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Viets, Henry R. Forced Grasping in Man and Its Localizing Significance. *New Eng. J. Med.* 210:675-678, and 708, March 29, 1934.

Kennard, Margaret A., Viets, H. R. and Fulton, J. F. The Syndrome of the Premotor Cortex in Man; Impairment of Skilled Movements, Forced Grasping, Spasticity and Vasometer Disturbance. Brain, 1934 (in press).

rell Harvey, Dr. Jesse P. Eddy, guest speaker, presented the "Indications for Blood Transfusion." In one hospital where ten transfusions per year were done before the Blood Transfusion Service was established, the number has now increased more than six fold. The direct method with multiple syringes has largely displaced the citrated technique. In the discussion, Dr. Francis H. Chafee maintained the advantage of the citrated method in those cases where it is inadvisable to move the patient to the operating room.

January 15. Dr. B. Earl Clarke entertained the William W. Keen Medical Club. Dr. Alfred L. Potter reported the "Advances in Obstretrics in the Last Ten Years."

January 18. At the regular meeting of the Thirty-four Medical Club, entertained by Dr. Linley C. Happ, Dr. Millard Smith of Boston described his "Experience with Koch's Gly-Oxalide." This somewhat discredited cancer cure has been used in the treatment of such diverse conditions as psoriasis, angina pectoris and epilepsy. Dr. Smith's discussion was illustrated with many lantern slides.

January 19. Dr. Frank A. Cummings entertained a group of physicians at his residence. Formation of a Rhode Island Chapter of the American Society for the Advancement of Gastro-enterology was discussed and approved. Dr. Charles W. McClure of the Boston City Hospital presented the advantages of such a Chapter, not only for specialists in gastro-enterology but for many other practitioners who are directly interested in this important work. It is planned later in the year to hold a meeting which the fellows of the Rhode Island Medical Society will be invited to attend.

January 22. Before the Providence Medical History Club, Dr. Roland Hammond reported on the recent meeting of the American Historical Association, held at Providence. Dr. A. H. Miller presented a paper on "Progress of Surgery in 1837."

January 22. The Friday Night Medical Club was entertained by Dr. Murray S. Danforth.

January 28. The Regular Quarterly Meeting of the Rhode Island Medico-Legal Society was held in the Medical Library Building at 5 P. M. Lester A. Round, Ph.D., Former Director of Public Health and State Pathologist, Rhode Island Department of Public Health, was the speaker; his subject, "Crime and Criminals."

Dr. Michael J. Nestor, Providence Superintendent of Health, announces that there is an increase in the incidence of scarlet fever above the usual seasonable limit. He calls to the attention of physicians and others that this is a reportable, placardable disease. Frequently the diagnosis is not made due to the atypical character of the disease. He reminds physicians that septic sore throat is also reportable. His department will be glad to assist physicians, at any time, to make a diagnosis of any atypical or suspected case.

Dr. Charles Bradley announces the opening of an office for private practice limited to neuropsychiatric disorders of childhood at the Emma Pendleton Bradley Home, Barrington Parkway, East Providence, R. I.

Rhode Island Hospital

On December 27th, 1936, the engagement was announced of Dr. Robert Murphy to Miss Elizabeth T. Walsh. Dr. Murphy is House Physician at the R. I. Hospital.

Born: On January 5th, 1937, at the Lying-In Hospital, to Dr. and Mrs. Daniel Young, a son—Daniel Charles.

Dr. Stephen J. Ryan of Providence, Providence College and McGill Medical 1935, has terminated his internship at the R. I. Hospital. Next week, Dr. Ryan leaves for Philadelphia to enter the Naval Hospital of that city.

Dr. Daniel McCooey of Dover, N. H., graduate of New Hampshire University and McGill Medical School, 1935, started internship at the R. I. Hospital on January 22. He will serve for four months, covering for Dr. Stephen Ryan. Dr. McCooey has been an interne at St. Luke's Hospital, Montreal, for the past eighteen months.

Dr. Lawrence T. Minish of Frankfort, Ky., graduate of the University of Louisville Medical School, started his internship at the R. I. Hospital on January 15.

On December 17, 1936, Dr. Eric Stone was elected President of the Consumers League of Rhode Island.

St. Joseph's Hospital

The time of the monthly meetings of the Staff Association of St. Joseph's Hospital has been changed from the evening to the noon hour on the second Thursday each month. Thursday, January 14, Rt. Rev. Msgr. Peter E. Blessing gave the Introductory Address. Dr. H. B. C. Riemer, Instructor in the Department of Ophthalmology at Harvard Medical School, presented a paper on "Diseases and Injuries of the Eye in Daily Practice." The subject was discussed by Dr. Joseph E. Dowling.

Memorial Hospital

At the clinical pathological conference held January 13, 1937, the following cases were presented:

1. By Drs. Earl F. Kelly, Charles H. Holt and William P. Davis. A case of intussusception of the ileum with a recurrence of the intussusception not at the original site but at the ileo-cecal junction. The second intussusception was of the cecum and ascending colon into the transverse colon.

2. By Drs. F. V. Hussey and Dr. John F. Kenney. A case of total ablation of thyroid with com-

plete cessation of all symptoms following total ablation.

3. By Dr. Jesse P. Eddy, III. A case of vegetative endocarditis following an infection of the right kidney.

Dr. Parker Carpenter is practicing at Springfield, Vermont.

Dr. Robert S. Sherman is at the Long Island Hospital, Brooklyn, N. Y.

Dr. A. H. Miller has been placed on the Consulting Staff and Dr. Meyer Saklad has been placed in charge of the Department of Anesthesia. Dr. Elihu Saklad has been appointed as assistant in this department.

Dr. John F. Kenney, Chief of the Medical Service, addressed the Rhode Island League of Nursing at Ray Hall, Butler Hospital, on January 21, 1937. His subject was "Advances Made in Foreign and American Medicine."

Minutes of the Caduceus Club

The Annual Banquet of the Caduceus Club was held at the T. K. Club, January 11, 1937. Dr. Berlin, guest speaker for the evening, was unable to attend, due to illness. Dr. Edward A. McLaughlin, State Director of Public Health, and Dr. Ernest A. Burrows, representative of the East Providence Physicians Association, were guest speakers.

Dr. McLaughlin, outlined the program for the Health Department since its reorganization and explained in detail the relationship between the United States Public Health Service and the State Department of Health.

Dr. Burrows congratulated the members of the Caduceus Club on their excellent organization and commented on the good work they were doing in the community.

Following the banquet, the business meeting was called to order by President Krolicki. As Retiring President, Dr. Krolicki thanked the club members for their excellent cooperation and stated that he deemed it a pleasure to have served as first President of the Caduceus Club. The Annual reports of the Secretary and Treasurer were read and approved.

The Election of officers for the ensuing year was then called for by the President. Dr. Earl J. Mara, formerly Vice-President of the Club, was elected to the Presidency by a unanimous vote. Dr. Joseph Doll was elected Vice-President. Drs. George B. McClellan and Orland F. Smith were re-elected to the offices of Secretary and Treasurer, respectively. Dr. Mara made a brief speech of acceptance, following which the meeting was adjourned.

Respectfully submitted,

GEORGE B. MCCLELLAN, M.D.,
Secretary.

IMPORTANT NOTICE

"No patient can be accepted in any Out-Patient Clinic in the Division of Hospitals and Infirmaries who does not present a written reference from a physician registered in the state."

The above order is effective as of November 20th, 1936, and was issued by Doctor Charles A. McDonald, Chief of Division of Hospitals and Infirmaries of the Department of Public Welfare. All physicians should cooperate by sending a written order with each patient referred to tuberculosis or other State operated clinics under jurisdiction of the division.

The Committee on Public Health Clinics, in its efforts to correct the abuses of the free clinic requests that the physicians refer to the clinics only those persons unable to pay for medical care; and to determine such inability by an investigation into the financial status of the patient.

The Social Service Department of the State Sanatorium now has supervisory control over the ability of patients now in clinics and about to enter clinics as to their ability to pay. Since all new patients will be admitted only on the written order of a physician, all cases found not to be entitled to clinic care will be directly traceable to the physician referring and he will then be responsible for the breakdown of our efforts to correct clinic abuses.

CHARLES L. FARRELL, M.D.,
Chairman,
Committee on Public Health Clinics

RHODE ISLAND MEDICAL SOCIETY

Meeting of the Council

The regular quarterly meeting of the Council was held at the Medical Library Building, Thursday, November 19, 1936. The meeting was called to order by the President, Dr. John E. Donley, at 4 P. M. The Treasurer, Dr. Jesse E. Mowry, presented the following budget for the year 1937:

Income for 1937

Annual dues	$4,880.00
Interest from Harris Fund	206.00
Interest from Morgan Fund	22.50
Providence Medical Association	450.00
Use of Building	75.00
	$5,633.50
Balance in Bank November 1, 1936	1,226.19
	$6,859.69

Budget — 1937

Collations and Annual Dinner	$ 750.00
Expenses of Secretary	75.00
Printing and postage	155.00
Fuel	600.00
Gas	40.00
Electricity	90.00
Telephone	125.00
City water	15.00
House supplies and expenses	450.00
House repairs	300.00
Janitor	720.00
R. I. Medical Journal	400.00
Safe Deposit	7.00
Treasurer's Bond	25.00
Librarian	1,660.00
Delegate to American Medical Association	100.00
Medical Library Association Dues	10.00
Sunday Lectures	125.00
Insurance	231.00
	$5,878.00

Harris Fund

Central Arizona Light & Power Co.	$ 50.00
General Public Utilities Co.	156.00
Mortgage Security Corp. of America	
	$206.00

James R. Morgan Fund

Missouri Power & Light Co.	$22.50

J. W. C. Ely Fund

Rhode Island Public Service Co.	$74.00
Mechanics National Bank	
	$74.00

Frank L. Day Fund

Canadian National Railway	$135.00

Herbert Terry Fund

Providence Gas Company	$76.80

James H. Davenport Fund

Providence Gas Company	$71.20

Endowment Fund

Oklahoma Gas & Electric Co. (Added to Fund)	$100.00

On motion made by Dr. Lucius C. Kingman, seconded by Dr. Roland Hammond, this budget was recommended to the House of Delegates for adoption.

For the Publication Committee, Dr. Kingman discussed a plan for a budget incident to the publication of the RHODE ISLAND MEDICAL JOURNAL. Dr. Mowry advocated such a plan. The motion was then made, seconded and carried; that the situation in regard to finances for the publication of the JOURNAL be continued as is, and that Dr. Mowry continue to pay the bills as submitted and that ultimate disposition of the problem be left to the discretion of the Publication Committee. Meeting adjourned.

Respectfully submitted,
GUY W. WELLS, M.D.,
Secretary

Meeting of the House of Delegates

The regular quarterly meeting of the House of Delegates was held at the Medical Library Building, Thursday, November 19, 1936, and was called to order by the President, Dr. John E. Donley, at 5 P. M. The record of the meeting of the Council was read by the Secretary and was approved and placed on file. The Treasurer's budget as approved by the Council, was adopted and placed on file. The membership dues for 1937 were voted at $10.00.

The report of the Committee on the Change in By-Laws was read by the Chairman, Dr. Arthur T. Jones. The report was accepted and placed on file. Dr. Christie moved that the By-Laws be amended as recommended by the Committee and the motion was seconded by Dr. Mowry. After discussion by Drs. Farrell, DeWolf, Jones and Helfrich, it was voted to approve the report of the Committee and refer it to the General Session for adoption.

The Secretary read a letter from Mrs. Jane R. Leech, widow of Dr. James W. Leech, expressing to the members of the Rhode Island Medical Society her deep and sincere appreciation for their tribute to Dr. Leech.

Dr. Hammond moved that Dr. Guy W. Wells be elected Delegate to the American Medical Association. The motion was seconded and carried.

Dr. Skelton moved that the President appoint a nominating committee of five to report at the May meeting nominations for officers of the Society for the ensuing year. The motion was seconded and carried. Dr. Hammond moved that the current nominating committee bring in before the next meeting, a nomination to fill the vacancy of Second Vice President, left vacant by Dr. Leech's death. The motion was seconded and carried.

The House of Delegates was then addressed by Drs. John G. Walsh, Edward A. McLaughlin and Hugh E. Kiene. Dr. Walsh sought approval of a plan to establish for practitioners in hospitals or elsewhere, clinics for the improvement of obstetrical treatment. A motion was made to approve such a plan and the motion was carried.

Dr. McLaughlin then explained the work of the Public Health Service and its relation to medical practice. Dr. McLaughlin pointed out that work of the Public Health Department did not in any way infringe on the work of the practitioner and had no desire to do so, that maternal and child welfare work was done only with the approval of an advisory board as was that of crippled children.

Dr. Kiene spoke on the problem of the increasing number of patients suffering from mental disorders without available place for observation and treatment.

The meeting was then adjourned.

Respectfully submitted,
GUY W. WELLS, M.D., *Secretary*

Report of the Committee on Change in the By-laws

The Committee on Change in By-Laws recommends that the following amendments to the Rules and By-Laws of the Rhode Island Medical Society be made.

ARTICLE IV — MEMBERSHIP

Sec. 9. To read as follows:

Any member who may have forfeited for any cause his membership in his district society, upon notice to the secretary of this Society by the secretary of said district society, shall automatically cease to be a member of this Society until notice of the reinstatement in his district society has been received by the secretary of this Society. He may be reinstated as a fellow in this Society upon compliance with Sec. 8, Article IV of these By-Laws.

Present Section Numbers 9-12 inclusive to be changed to Section Numbers 10-13.

ARTICLE V — SESSIONS AND MEETINGS

Sec. 1. To be changed to read as follows:

There shall be one Annual Meeting of the Rhode Island Medical Society to be held in the City of Providence on the first Wednesday and Thursday in June. These meetings of two days shall consist of clinics and the reading and discussion of scientific papers. Each fellow shall receive written notice of this meeting at least two weeks before said meeting. By vote of the House of Delegates this meeting may be held in some other city in Rhode Island other than Providence once in each four years.

Sec. 2. Shall be omitted entirely.

Section Numbers 3-8 inclusive to be changed to Section Numbers 2-7 inclusive.

ARTICLE VII — COUNCIL

Sec. 2. To be changed to read as follows:

There shall be three regular meetings of the Council to be held in the City of Providence on the third Thursday of the month at four o'clock P. M. in January, May and September and other meetings as necessity requires subject to the call of the President or on petition of three members of the Council. Five members shall constitute a quorum.

ARTICLE VIII — HOUSE OF DELEGATES

Sec. 2. To be changed to read as follows:

There shall be three regular meetings of the House of Delegates to be held in the City of Providence on the third Thursday of the month in January, May and September at four-thirty, or immediately following the adjournment of the meeting of the Council at the same place and date; or other meetings as necessity requires subject to the call of the President or on petition of ten delegates or twenty-five fellows; fifteen members shall constitute a quorum.

Sec. 4. In the last paragraph in this section "November" to be changed to "September."

ARTICLE X — DUTIES OF OFFICERS

Sec. 1. To the first paragraph of Section 1 add "he shall report his appointments to the House of Delegates at the January meeting."

ARTICLE XI — COMMITTEES

Sec. 8. To be changed to read as follows:

The Board of Trustees of the Rhode Island Medical Society Building shall consist of seven members as follows: the Second Vice-President who shall be Chairman, the Chairman of the Library Committee, one member to be elected at the Annual Meeting in January by the Providence District Society, one member who shall not be a member of the Providence District Society to be appointed in December by the President, and the President, Secretary and Treasurer, ex-officio.

The remainder of this section to be not changed.

The Committee further recommends that the Secretary notify the Secretaries of the several District Societies of the change in the By-Laws and request that the Secretary of the Rhode Island Medical Society be immediately informed of the lapse in the membership of any of the fellows of the District Society.

Respectfully submitted,
ARTHUR T. JONES, M.D.
CHARLES F. GORMLY, M.D.
ALBERT H. MILLER, M.D.
NORMAN S. GARRISON, M.D.

Minutes of the Three Hundred and Fifty-sixth Regular Meeting

The regular quarterly meeting of the Rhode Island Medical Society was called to order by the President, Dr. John E. Donley, at 4 P. M. December 3, 1936. Since the minutes of the September meeting had been published in the Society's Journal, their reading was omitted. The minutes of the November meeting of the Council and the House of Delegates were read and approved.

The President appointed delegates to the New England Societies as follows:

Maine
Dr. Arthur T. Jones
Dr. Jesse P. Eddy
New Hampshire
Dr. Norman M. MacLeod
Dr. John P. Jones
Massachusetts
Dr. William A. Horan
Dr. Banice Feinberg
Connecticut
Dr. Frank B. Cutts
Dr. Ralph L. DiLeone
Vermont
Dr. Charles L. Phillips
Dr. Henri E. Gauthier

The President appointed Dr. Charles H. Holt a Member at Large of the Board of Trustees of the Rhode Island Medical Library Building. The President appointed Dr. Joseph C. O'Connell, Anniversary Chairman.

The President then read the announcement of the death of the following members and referred the names to the Committee on Necrology:

Dr. Horace P. Beck
Dr. Augustus W. Calder
Dr. Charles E. Chagnon
Dr. W. Louis Chapman
Dr. James W. Leech
Dr. John G. O'Meara

Dr. Arthur T. Jones explained the proposed Changes in the By-Laws. Dr. Albert H. Miller discussed the question and moved the adoption of the amendments as recommended by the Committee. The motion, seconded by Dr. Jesse E. Mowry, was carried.

Dr. Charles Bradley reported for the Publicity Committee, asking for brief abstracts of papers read before the District Societies, at least three days in advance of the meetings.

The Scientific Program followed:

1. Surgery in the Management of Pulmonary Tuberculosis. Eske H. Windsberg, M. D.
2. The Neurosurgical Treatment of Visceral Pain. James C. White, M.D., Department of Neurosurgery, Harvard Medical School.
3. Lipiodol in Neurological Diagnosis. James B. Ayer, M.D., Department of Neurosurgery, Harvard Medical School.

Dr. Ayer spoke on the subject of the spinal fluid and the use of lipiodol in various diseases of the spinal cord and cauda equina. He began with an historical resume of the development of spinal fluid studies in this connection.

"The first work of importance was by Froin, who in 1903 spoke of a highly albuminous fluid which was yellow and contained cells. This fluid was found to indicate inflammatory block above the point of puncture. Since his time many such fluids have been found and yellow fluids with high protein content but without cells, obtained below tumors, are even more numerous. However, all of these fluids are usually spoken of as showing the Froin syndrome. The subject was extended in 1912 by Raven, who published a series of cases of spinal tuberculosis with cord compression, in whom the fluids were clear and colorless but showed elevation of protein without cells. In 1916 Quackenstedt first mentioned the use of jugular compression as an indication of whether or not a spinal subarachnoid block was present. In 1920 there was developed at the Massachusetts General Hospital the cisternal-lumbar puncture technique, which shows with greater certainty than lumbar puncture alone the presence or absence of block, and a modification of this technique, which may be called multiple spinal punctures, is occasionally utilized to show multiple loculation of fluid.

"*Lipiodol*, with which we are chiefly concerned tonight, was first used by Sicard and Forrestier in 1921, and has become a method of investigation as you know, in many cavities of the body. We have used it repeatedly and without hesitation in many cases in the subarachnoid spaces and see no reason to fear its use, although it must be admitted that when not removed it remains in the sacral canal, as far as we know, indefinitely.

"*Technique:* There are two principal methods of use of lipiodol. The original and perhaps the most common use is in determining block in the cervical, dorsal or upper lumbar region. A second use has become of increasing value, namely, its use *in demonstrating a filling defect* in the lumbo-sacral portion of the subarachnoid space. A somewhat different technique is carried out in the two groups of cases. In order to show spinal subarachnoid block it is customary with us to inject two c.c. of lipiodol into the cisterna magna with the patient in horizontal position. The patient is then placed on a tilt table and the head elevated slightly, the movement of the lipiodol column being observed through the fluoroscope. Spot films are taken at intervals if an obstruction becomes visible. Frequently it is of value to repeat the films on subsequent days to see if the arrest of oil remains at the original point. By this means we are able to determine partial as well as complete block, and to visualize in many cases on which side the compression exists. In experienced hands one may often differentiate intra-medullary from extra-medullary growths, and these again from extra-dural compression. In order to demonstrate a filling defect in the lumbo-sacral subarachnoid space a much larger amount of lipiodol should be injected, at least five c.c. This is best introduced into the upper lumbar region in order to keep the mass together. The patient is then maintained erect with the idea of filling not only the subarachnoid space, but in order to force oil out into the arachnoidal projections accompanying the caudal roots. Films are then taken, not only anteroposterior and lateral, but also in tangenital planes, and if the fluoroscope is used, certain lesions, notably ruptured discs, are best found with the patient lying prone.

"One or two other points of technique should be mentioned. A needle of not less than 18-gauge should be employed, as the oil is very heavy. The oil itself should be warmed before introduction, especially for cisternal use, and the injection once started should not be interrupted or the oil will enter the fluid pathways as droplets instead of as one continuous mass. Separate globules are very likely to be caught up in the subarachnoid space by the nerve roots, showing as false arrest."

Lantern slides were then shown indicating the various types of lesions already mentioned.

The meeting was adjourned. Collation followed.

Respectfully submitted,
GUY W. WELLS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the Eighty-ninth Annual Meeting

The Annual Meeting of the Providence Medical Association was called to order by the President, Dr. William S. Streker, Monday, January 4, 1937, at 8:55 P. M. The minutes of the last meeting were read and accepted. The annual reports of the Secretary, the Standing Committee, the Reading Room Committee and the Medical Milk Commission were read and accepted. The report of the Treasurer was read by the Secretary.

The Annual Address of the President was given by Dr. William S. Streker, who discussed social and economic problems of the medical profession and of our Association. He suggested that the Association consider the advisability of having a full time Executive Secretary. The election of officers then took place. On motion of Dr. Jesse E. Mowry, seconded by Dr. Jacob S. Kelley, the Secretary cast one ballot for the following officers and committees, who were then declared elected:

President—Peter Pineo Chase.

Vice-President—Alex M. Burgess.

Secretary—Herman A. Lawson.

Treasurer—Charles F. Deacon.

Member of the Standing Committee for five years—William S. Streker.

Member of the Standing Committee to complete the unexpired term of Dr. James W. Leech—John E. Donley.

Trustee of the Rhode Island Medical Library for one year—Charles F. Deacon.

Reading Room Committee—Elihu Wing, Guy W. Wells, Frank E. McEvoy.

Councilor for two years—Charles F. Gormly.

Delegates to the House of Delegates of the Rhode Island Medical Society—Wm. Hindle, C. W. Skelton, P. P. Chase, L. C. Happ, W. C. Gordon, W. M. Muncy, J. J. McCaffrey, C. B. Leech, A. J. Pedorella, J. M. Beardsley, C. R. Doten, H. J. Gallagher, N. A. Bolotow, Jos. Franklin, Chas. Bradley, W. S. Streker, H. A. Lawson, J. P. Eddy, 3d, D. V. Troppoli, M. Adelman, F. Ronchese, A. M. Burgess, G. F. White, M. Saklad, J. A. Hayward.

The newly elected President, Dr. Peter P. Chase, then announced the following appointments:

To the Medical Milk Commission for five years—Dr. Harold G. Calder and Dr. Reginald A. Allen.

To the Committee on Ethics and Deportment for five years—Dr. Frank E. McEvoy and Dr. James E. Boyd.

To the Donors' Bureau—Dr. John G. Walsh and Dr. Edward J. West, to replace Drs. Gregory and Waterman.

To the Public Relations Committee—Dr. Joseph L. Belliotti and Dr. Louis I. Kramer, to replace Drs. Sawyer and Garside.

To the Collation Committee—Dr. Wallace Lisbon.

The Committee on the Care of the Low Income Group was continued.

The Committees on Welfare of Deafened Children, on Public Health Clinics, on Unemployment Relief, and on Improvements in the Meeting Place were declared discharged.

The following Obituary Committees were appointed: for the late J. Edward McCabe, Drs. Edward F. Burke and Parker Mills; for the late Frank J. Jones, Drs. Joseph L. Belliotti and John J. Kenney; for the late Dr. George E. Clark, Drs. Niles Westcott and Ira C. Nichols.

The Standing Committee having approved the application of Dr. John Cyril Myrick, he was elected a member of the Providence Medical Association.

It was voted that the President appoint a committee of five members, with the President an ex-officio member, to consider the advisability of reorganization as recommended in the President's Address.

The following appropriations were voted: for the use of the Library Building, $450; for binding periodicals, $250; for subscription to periodicals, $250.

It was voted that the annual dues be $5.00 for the ensuing year.

Dr. Edward A. McLaughlin, Director of the State Department of Health, then addressed the meeting on the "Reorganized State Department of Health."

Dr. Alex. M. Burgess then spoke of the prevalence of influenza and other respiratory infections and of the probability of an increase in the incidence of pneumonia, many cases of which can be successfully treated by serum. Dr. Burgess felt that some effort should be made to provide serum for those patients unable to pay for it and made a motion that the State Department of Health be requested to provide serum for the treatment of pneumonia in those patients unable to purchase the serum, the distribution to be under such supervision as the State Department of Health may deem wise. The motion was seconded by Dr. Gormly and unanimously adopted by the Association.

Dr. J. Edwards Kerney then demonstrated a specimen and gave the case report of an unusual case of cyst of the kidney. The meeting adjourned at 10:45 P. M. Attendance 122. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

Report of the Milk Commission

Certified Milk in Providence during 1936 was obtained from the following farms: Cocumcussoc Farm, Wickford, R. I.; Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass. Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of the milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. Biological assays of Vitamin D Milk were performed in the Biological Laboratory at Brown University by Dr. Phillip Mitchell. These assays showed that each milk contained over 430 U.S.P. units of Vitamin D per quart. All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella Abortus infections.

During the past year pamphlets have been given to many of the new mothers to acquaint them of the qualities of certified milk. Advertising material and reprints concerning certified milk have been sent to most of the members of the medical society.

The personnel of the Commission includes Drs. Harold G. Calder, Chairman; Reginald A. Allen, Banice Feinberg, William Hindle, George W. Waterman, Raymond L. Webster, Henry E. Utter, Reuben C. Bates, Secretary and Treasurer.

REUBEN C. BATES, M.D.,
Secretary

Annual Report of the Treasurer

Receipts	
Cash on hand January 1, 1936	$1,423.37
Checks not cashed December, 1935	95.25
	$1,328.12
Annual Dues	2,175.00
Checks not cashed December, 1936	118.05
	$3,621.17
Expenditures	
Donation, Rhode Island Medical Society	$ 450.00
Collations	706.00
Medical Journals	249.75
Binding Journals	248.29
General Expenses	319.98
Secretary to the Treasurer	150.00
	$2,124.02
Cash on hand January 1, 1937	1,497.15
	$3,621.17

Journals Subscribed for in 1936

American Journal of Diseases of Children, American Journal of Obstetrics and Gynecology, American Journal of Roentgenology, American Journal of Surgery, American Journal of Syphilis, American Review of Tuberculosis, Annals of Surgery, Archives of Dermatology and Syphilology, Archives of Neurology and Psychiatry, Archives of Ophthalmology, Archives of Otolaryngology, Archives of Pediatrics, Archives of Surgery, Brain, British Medical Journal, Bulletin Institute History of Medicine, Bulletin Johns Hopkins Hospital, Hygeia, Journal of Bone and Joint Surgery, Journal of Experimental Medicine, Journal of Infectious Diseases, Journal of Nervous and Mental Disease, Journal of Pediatrics, Journal of Thoracic Surgery, Lancet, Medical Journal and Record, Military Surgeon, Modern Hospital, Quarterly Cumulative Index, Surgery, Gynecology and Obstetrics, Surgical Clinics of North America.

MONTHLY AVERAGES CERTIFIED MILK — 1936

	COCUMCUSSOC			CHERRY HILL (H. P. Hood)			FAIROAKS			HAMPSHIRE HILLS (Whiting)			WALKER-GORDON		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	4.4	13.37	9,922	4.3	13.19	2,325	4.3	13.15	1,118	4.0	12.86	1*	4.1	12.84	3,750
February	4.2	13.11	4,468	4.3	13.22	2,262	4.5	13.47	862	4.1	12.90	1	4.1	12.88	2,550
March	4.3	13.23	4,877	4.1	13.00	3,375	4.1	12.98	650	4.0	12.88	1	4.0	12.73	3,725
April	4.3	13.18	5,422	4.2	12.99	2,970	4.5	13.34	644	4.0	12.82	0	3.9	12.67	3,650
May	4.3	13.17	7,968	4.2	12.85	2,637	4.3	12.96	5,594	4.0	12.78	1	3.9	12.53	3,375
June	4.4	13.17	1,944	4.0	12.67	2,787	4.2	12.70	1,344	3.9	12.77	2	4.1	12.56	4,500
July	4.5	13.29	2,994	3.9	12.62	3,120	5.2	13.68	3,233	3.9	12.72	2	4.2	12.77	6,750
August	4.3	13.05	13,237	4.0	12.86	4,150	4.0	12.87	4,850	3.9	12.75	2	4.2	12.81	4,800
September	4.3	13.13	13,900	4.1	12.85	3,112	4.0	12.85	4,455	4.2	13.04	4	4.1	12.85	5,600
October	4.5	13.29	1,161	4.4	13.12	3,050	4.4	13.28	3,127	4.3	13.20	1	4.0	12.73	4,790
November	4.8	13.51	2,412	4.3	13.17	2,887	4.3	13.30	2,250	4.4	13.27	2	4.0	12.76	5,900
December	4.1	13.02	2,045	4.2	13.16	3,030	4.6	13.73	2,935	4.3	13.21	0	4.0	12.77	3,780
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In This Number

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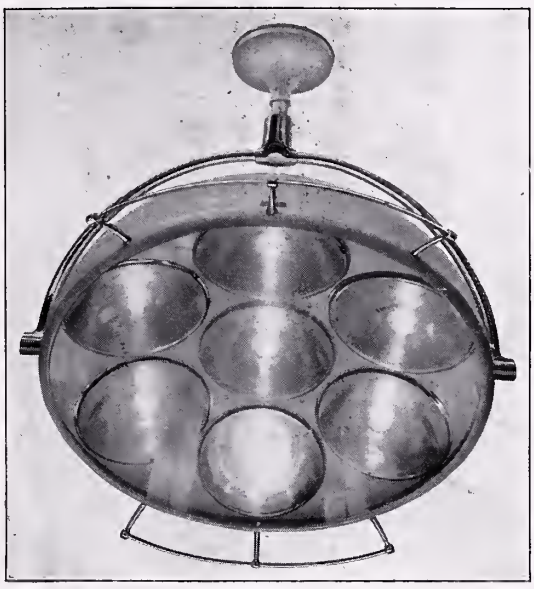
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Vitamin C intake of this order of magnitude prevents the development of clinical scurvy, however, it is probably inadequate for optimum nutrition. Clear cut cases of scurvy seldom are seen in this country although some authorities believe that symptoms of a mild deficiency of vitamin C are not uncommon (2).

Referring to nutritional deficiency diseases in general it has been said that. "Almost every tissue in the body may be affected by a deficiency in a food factor" (3).

The tissues generally recognized as affected by deficiency of vitamin C are the endothelium of the blood vessels and the teeth. It has been suggested that to prevent the development of subclinical symptoms, a daily intake of 380 to 540 International units of vitamin C is required for a 130 pound adult (4).

Thus it would appear that the optimum intake of vitamin C is at least twice the amount required to protect against scurvy.

Data recently published demonstrate that the vitamin C content of human milk is dependent upon the vitamin C content of the maternal diet (5).

Hence when the diet of the lactating mother is low in vitamin C, this factor is also deficient in the milk.

The League of Nations Technical Commission recommends an intake of over 500 International units per day during pregnancy and lactation (6).

The inclusion in the diet of liberal quantities of fruits and vegetables, prepared in such a manner as to retain a major portion of the original vitamin C content, may be relied upon to supply the need for this vitamin. The value of commercially canned foods as anti-scorbutics has been repeatedly demonstrated during the past decade (7).

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(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 71
(2) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 421 MacMillan, New York
(3) 1936. J. Am. Med. Assn. 106, 261
(4) 1934. Nature 134, 569
(5) 1936. J. Nutrition 11, 599
(6) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(7) a. 1925. Ind. Eng. Chem. 17, 59
b. 1928. Ibid. 20, 202
c. 1933. Ibid. 25, 682
(8) a. 1935. J. Nutrition 9, 667
b. 1936. Ibid. 11, 383
c. 1936. Ibid. 12, 405

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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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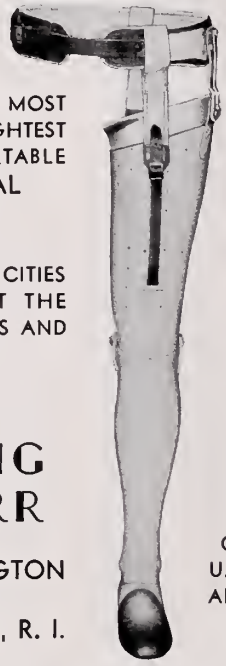
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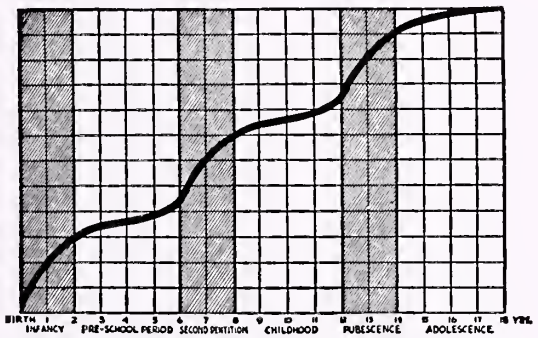
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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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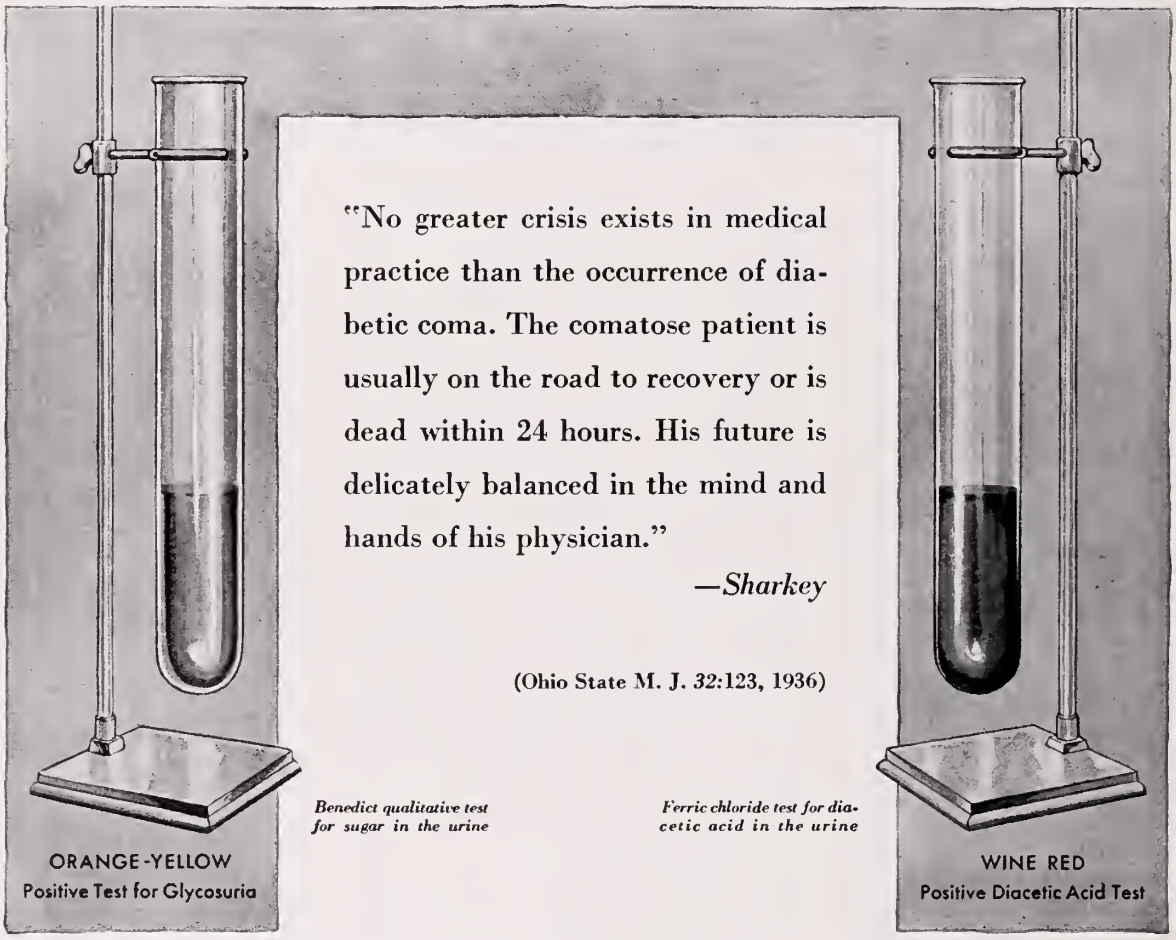
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Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 3 | Whole No. 330 | PROVIDENCE, R. I., MARCH, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

SURGERY IN THE MANAGEMENT OF PULMONARY TUBERCULOSIS

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Surgery in the management of pulmonary tuberculosis has, during the past decade especially, established its indispensable value. The relatively low operative mortality and the relatively high percentage of practical and clinical cures made possible in a specific group of patients whose future is otherwise considered hopeless, recommend this field of surgery both to the afflicted and to the physicians who are privileged to guide them. In this presentation, the rational basis for the value of surgery, its indications, and the common operative procedures employed, will be discussed. Finally, the author's limited experience in this work during the past five and one-half years will be cited.

The effectiveness of surgery as employed today in the management of pulmonary tuberculosis is due chiefly to the fact that it carries out the fundamental principle of rest. During the 55 years since Koch discovered the tubercle bacillus, rest is the only method of treatment of phthisis which has stood the test of time and has consistently resulted in cures.[1] The sanatorium, with its facilities for carrying out prolonged bed treatment is still the most important factor in the management of this ailment. Whereas the routine of the sanatorium conserves all of the body functions, pneumothorax, phrenic nerve interruption, and plastic operations are employed, when indicated, to bring about rest which is localized to the affected lung tissues.

Extending the principle of rest is not the only aim of surgery in this field. Extrapleural pneumolysis and thoracoplasty, by effecting the closure of pulmonary cavities, arrest hemorrhage, promote healing and create anaerobic conditions which are unfavorable for the growth of the tubercle bacillus.[2, 3]

From the State Sanatorium, Wallum Lake, R. I.
Presented before the quarterly meeting of the Rhode Island Medical Society, December 3, 1936.
The author wishes to express his great appreciation to Dr. R. Lemley Garrard and the members of his staff at the State Sanatorium, without whose help and counsel this presentation would have been impossible.

When is surgery indicated in the treatment of pulmonary tuberculosis? To answer this question strikingly, the management of pulmonary tuberculosis may be compared to that of peptic ulcer. In the latter, surgery is employed for such complications as large chronic ulcers, repeated hemorrhages, obstruction, penetrating ulcers and perforation. Likewise it may in general be stated that surgery is employed for the complications of phthisis. Thus, chronic cases with persistent cavities or recurring hemorrhages, patients not sufficiently improved by conservative measures, by sanatorium care, and pneumothorax failures, are the ones who present the indications for surgical interference. To depart from comparisons which at best are inadequate, surgery concerns itself especially with the closure of cavities. Whether one considers the cavity as an essential part of phthisis or one looks upon the cavity in the nature of a complication of the disease is not of practical importance. Patients having persistently open cavities should have the benefit of competent surgical consultation and the advisability of applying operative collapse strongly considered.

Graeff,[4] in 1921, stated that the cavity is like a death sentence to its bearer. The late Dr. Barnes,[5] in studies at Wallum Lake, reviewed 1,454 cavity cases without selection, unilateral and bilateral, small and giant, acute or chronic, near the onset or near the end. He found that 80% died within one year, 90% within five years. In a later study Barnes[6] tabulated the outcome in a series of 50 patients, taken at random, with small unilateral cavities, who were proper subjects for thoracoplasty but who did not receive it. Of the entire group of 50, 40% were dead at the end of three years; of 44 patients who were followed for five years, 75% were dead. (Table 4) Other investigations point to a similar grave prognosis for the cavity patients.[7, 8, 16] It is fair to conclude that about 20% of cavities will close with proper bed rest, that the longer a cavity has remained open, and the more chronic the case, the less chance there is for spontaneous closure. This grave outlook for persistent cavity cases approaches that for malignancy and is relatively of more serious portent since in tuberculosis we are

dealing with younger individuals. In addition, the persistent cavity case is always casting off tubercle bacilli and constitutes a problem in public health.

Aside from the cavity, the phthisiologist and surgeon must consider the nature of the predominating lesion in the lung before advising operation. As a practical guide, patients are classified as having predominatingly acute exudative, or chronic productive and fibrotic types of tuberculosis.[9] Surgery is infrequently recommended for patients having the acute exudative type; these are treated by bed rest usually supplemented with pneumothorax. In more than half of these individuals their small (less than 2.5 cm.) cavities with thin and soft walls will close spontaneously when confined to bed 22 to 24 hours daily for a period of six to eighteen months.[4] Of the chronic productive and fibrotic types of lesions, which present diffuse scarring of the lungs, often with deformities and displacements of the heart and trachea and narrowing of the intercostal spaces, only a small percent will recede with bed treatment; and their accompanying cavities which are thick, hard walled and of irregular outline, will seldom close spontaneously.

Finally, in the selection of patients it is usually those with unilateral involvement for whom surgical collapse is recommended. Very few cases meet this demand; often we have to deal with patients who have far advanced tuberculosis of one lung with cavity formation, and in whom the other lung contains either a healed and quiescent or a small exudative lesion. Experience has demonstrated that if the cavity on the worse side is closed, then the exudative lesion on the so-called good side will sometimes disappear. Patients having bilateral cavitation limited to the apex of each lung may be selected for bilateral thoracoplasty or a combination of thoracoplasty and apicolysis.

The Type of Operation

Churchill[10] has aptly stated that, whereas the selection of patients for operation is of emphatic importance, "the case of every patient with pulmonary tuberculosis is to be reviewed at frequent intervals with the question: 'What type of operative interference may we suggest in this case at this time?'" A discussion of pneumothorax is not within the scope of this presentation. However, it may be stated here that pneumothorax is still the procedure of choice whenever it can be induced. Some surgeons and specialists in pulmonary tuberculosis[11] already realize that lasting cure can be obtained in selected patients in a much shorter time by means of some form of thoracoplastic collapse than is possible by means of pneumothorax, and with no greater mortality. The prediction is that in the future this point of view will be more widely adopted. Especially for patients with cavitation limited to the apex, it is probably more conservative to perform a 3 rib thoracoplasty combined with extrafascial pneumolysis, than to collapse the whole lung by means of pneumothorax for a period of two years or more. In this class of patient, a more certain chance of arresting the disease, after a shorter time interval, can be predicted by means of operation, than by pneumothorax, and with no greater risk.

Intrapleural Pneumolysis: As an adjunct to pneumothorax there is an operative procedure, intrapleural pneumolysis, which is often necessary in order to convert an ineffective collapse to one which is effective. Adhesions in the form of strings, bands, or stalks, extending from the surface of the lung to the chest wall, may prevent a cavity from closing. Only those adhesions which are obviously holding the cavity open need be cut; severing others is not necessary and is often dangerous. Not all offending adhesions can be safely cut by this method. The insertion of a thoracoscope into the thorax, under local anesthesia, is entirely without danger and visualization and transillumination of the involved adhesions enable one to determine whether they can be interrupted safely with a cautery.[12] The X-ray is not to be relied upon. When the offending adhesions cannot be managed by this method, open pneumolysis or some form of plastic operation is advised. For the procedure of open pneumolysis the thorax is entered through an intercostal incision or by the removal of a section of a rib, and the adhesions are cut under direct control and vision. This method, although entirely feasible, is rarely indicated.

Intrapleural pneumolysis is not without danger. Sudden death from air embolism, dangerous hemorrhage, and complicating empyema are the pitfalls. Therefore, in the absence of other contraindicating factors, it is preferable to discontinue the inadequate pneumothorax and resort to a plastic procedure rather than attempt the cauterization of adhesions which are too complicated to manage with facility.

In 22 instances of intrapleural pneumolysis the writer has had one death from cerebral air embo-

TABLE 1.
Wilms-Sauerbruch Thoracoplasty: 19 patients, 46 operations.

	Sex	Age	Date of Op's	Stages Ribs	Acid Fast	Result	Remarks
1.	F	26	8/31	4-5-2	—	P. C.	Patient considers herself entirely well. Does full time housework.
2.	M	31	10/31	5-4-2		L. D.	Died 8/32 of tuberculosis. Was unimproved.
3.	M	27	11/31	6-5	#	I.	Reoperated. Table 2, No. 2.
4.	M	22	12/31	6-3-2	—	P. C.	Was working. Suicide 7/34.
5.	F	33	12/31	5-6	—	U.	Sputum negative. Often raises blood.
6.	M	32	3/32	6-5-6a	—	I.	Marked dyspnea.
7.	F	28	4/32	5-4-2	—	P. C.	No sputum, no dyspnea, keeping house.
8.	M	32	4/32	4-4	—	G. I.	Radio operator, full time.
9.	F	43	6/32	5-6	0	P. C.	No sputum. All housework.
10.	F	24	8/32	6-5	—	G. I.	2 ch. since op. Some housework.
11.	M	28	8/32	6-5	—	G. I.	Working part-time.
12.	F	14	8/32	6-5	—	P. C.	Housework.
13.	F	43	9/32	6-2		L. D.	Died 6/36 of tb. Temporary impr.
14.	M	22	9/32	6-5	0	P. C.	Working full time; entirely well.
15.	F	29	10/32	6-5-2a	—	G. I.	Married since. Light housework.
16.	F	25	11/32	5-4-3a	0	P. C.	
17.	M	44	11/32	7-4		L. D.	Died 6/36. Was doing light work.
18.	M	26	12/32	6-5	—	P. C.	Auto service, full time.
19.	M	51	4/33	5-3a-6		I.	Recently returned to sanatorium.

NOTATIONS

— Positive.
P. C. — Practical cure, free from all symptoms of tuberculosis and able to perform a full day's work.
G. I. — Greatly improved, often referred to as clinical cures. Able to perform light work or a satisfactory day's work. May have a small amount of sputum negative for tubercle bacilli, otherwise they are free from the symptoms of the disease.
I. — Improved, unable to work, sputum usually still positive, have to continue curing.
L. D. — Late death, not connected in any way with the operation.

lism. A small vein near the anterior mediastinum was inadvertently opened into. A very slow trickle of blood, about 30 drops to the minute, was noted. Facial twitchings and epileptiform convulsions and unconsciousness occurred almost instantly. Supportive measures failed and death ensued in about seven minutes. In another instance, an intercostal artery which was pulled down by an adhesion began to bleed profusely, and had to be ligated and controlled by open thoracotomy.

Phrenic nerve interruption removes the activating mechanism of the hemi-diaphragm, and allows it to remain in an elevated position. This results in relaxation of the lung structure which may bring about the desired closure of a cavity. More often than not, this simple and apparently harmless operation, performed under local anesthesia through a small incision about the clavicle, proves disappointing. It is sometimes dangerous, for, while waiting in fond hope that the cavity will close, the patient loses the opportunity for effective operative collapse by virtue of an embarrassing spread of the disease to the other lung. The most common practice today calls for a temporary paralysis of the nerve by crushing. If distinct benefit is noted after approximately six weeks, especially if the cavity has closed, the paralysis is made permanent by the "removal" of the nerve. Otherwise, no further time should be lost in carrying out a plastic operation unless pneumothorax is thought advisable and can be induced.

Apicolysis with extra-pleural packing, or plombage, is a selective type of collapse that has been used especially in European and Scandinavian countries. Under local anesthesia, through a small area where a section of rib has been removed, the affected, cavity containing, apical portion of the lung is freed extrapleurally from the dome of the chest. The apex of the lung is then fixed in a collapsed position by placing beneath the upper ribs a permanent (paraffin, fat) or temporary (rubber dam, gauze, inflated bags) packing. It is a relatively simple procedure and has resulted in many cures. The introduction of foreign substances, however, is not appealing. These often slough into the lung especially into thin walled cavities near the surface, and create bronchial fistulae. It is definitely indicated in those patients in whom it is imperative to close a cavity quickly by a plastic procedure, and who are too ill, too old, or present other serious contraindications to thoracoplasty. It should not be recommended as a substitute to those who are proper subjects for thoracoplasty merely because of its simplicity. In two patients in whom this procedure was carried out one cure was obtained and one failure. In the latter, there has been marked clinical improvement but the patient has a bronchial fistula.

TABLE 2.

Brauer Thoracoplasties: 24 patients, 42 operations.

	Sex	Age	Date of Op's	Stages Ribs	Acid Fast	Result	Remarks
1.	M	31	8/31	Atypical	#	I.	Reoperated, see table 1, No. 8.
2.	M	28	12/32	5-4a	—	P. C.	Laborer, full time.
3.	M	55	2/33	5	#	U.	Unimproved. Incomplete operation.
4.	F	39	5/33	5		O. D.	Pneumonia, contra-lateral lung, died 8th post-op. day.
5.	F	31	8/33	3-5	—	P. C.	Housekeeping.
6.	F	38	9/33	3-5	—	P. C.	Housekeeping.
7.	M	33	9/33	4	—	M. I.	Still at san. Bilateral cavitation to begin with. Needs further surgery.
8.	M	29	10/33	5		O. D.	Chest wall flutter and anoxemia; died 5th post-op. day.
9.	M	33	11/33	3-4	—	P.C.(L.D.)	Died 2 years later. Autopsy: generalized miliary tb./ superimposed infection.
10.	F	26	12/33	3-3	#	I.	Reoperated by method of Semb. Has no sputum now. Will be a P. C.
11.	F	29	1/34	3-4		O. D.	Chest wall flutter, pneumonia lower lobe same side; died 6th day p. op.
12.	F	30	1/34	3-3	—	P. C.	Housework, 1 child since op.
13.	M	33	1/34	3	#	W.	Incomplete op. Putrid lung abscess same side, following 1st stage.
14.	F	22	1/34	3		O. D.	Auto-tuberculinization, died 4th day post-op., hyperpyrexia, 108 F.
15.	F	27	2/34	3-3-3	—	P. C.	Housework.
16.	F	26	4/34	2-2	—	P. C.	Attends high school; all activities.
17.	M	42	11/34	3-3	—	G. I.	Not working, but able to do light work.
18.	F	26	4/35	3-3	—	P. C.	Ill 8 yrs., at sanatorium 7 yrs. before operation. Entirely well now.
19.	F	36	6/33	3-3	—	M. I.	Still at sanatorium.
21.	M	28	10/35	3-3	#	U.	Reoperated by method of Semb, 10/36, too soon for final classification.
20.	M	31	9/35	3-3	#	U.	Unimproved by operation. At sanatorium.
22.	F	29	10/35	3-2	#	U.	Had severe bronchiectasis of lower lobe of same side before operation.
23.	M	47	10/35	3-3	#	I.	
24.	M	29	4/36	3-3	#	M. I.	Still at sanatorium. Bronchial fistula following plombage 5/35.

NOTATIONS

U., unimproved; O. D., operative death; W., worse; M. I., moderately improved. Other notations same as table 1.

Thoracoplasty as employed in the management of pulmonary tuberculosis is a collapse operation which involves the subperiosteal resection of entire ribs or segments of ribs. The soft parts of the chest wall are allowed to fall in; from the periosteum new bone is formed in the collapsed position, and the rigidity essential to the thoracic mechanism is thus re-established. Obvious deformity as a result of the operation is only rarely apparent; more often a scoliosis, due to the retraction of the chest wall on the involved side, is corrected by means of the operation. (Alexander)

Until recently the so-called *Wilms-Sauerbruch operation* was employed. It is an excellent operation and many cures were obtained by its means, with a relatively low mortality when carried out in two or more stages. In this operation small segments usually of all the ribs were removed close to the spine. In patients having very large cavities the overlying transverse processes posteriorly and the overlying ribs antero-laterally were also resected. The Wilms-Sauerbruch type of operation was employed by the author in 19 patients. Four of these required supplementary antero-lateral rib resections. Table 1 is an analysis of this group of 19 patients showing the approximate date of operation, the number of ribs removed at each stage and the results. There were no operative deaths in this group. One patient died 10 months after operation from the natural progress of his disease. He was a patient who had been steadily getting worse; the operation did not influence his condition favorably or unfavorably. Another patient committed suicide 3 years after operation. He was a clinical cure, free from all signs and symptoms, and had been working. Two other patients, who were temporarily improved by the operation died forty-two months, and forty-five months, respectively, after surgical collapse. Twelve patients have their disease arrested; eight of these are entirely well (practical

TABLE 3.

Combined Thoracoplasty and Extra-facial Pneumolysis.

	Sex	Age	Date of Op's	Stages Ribs	Acid Fast	Result	Remarks
1.	F	29	8/36	3	0	G. I.	Practical cure predicted.
2.	M	29	10/36	3	#	U.	Still at sanatorium.
3.	F	22	11/36	3	0	G. I.	Has lost all sputum since op. Practical cure predicted.

TABLE 4.

Tabulation of Cases With and Without Operation.

	No. of Cases	Pract. Cures	G. I.	I.	U.	W.	Deaths Op.	Deaths Late	Deaths Total
Sauerbruch	19	8	4	3	1		0	3	3
Brauer	24	7	2	5	4	1	4	1[a]	5
Semb	3		2		1		0	0	0
Total { 46 thoracopl. 42 patients 92 operations	42	15	8	5	5	1	4	4	8
		35%	20%	12%	12%	2%	9.5%	9.5%	19%
Average 3.2 years			54% Arrested						
No operation (Barnes):									
End of 3 yrs.	50							20	40%
End of 5 yrs.	44							33	75%
Freedlander[16] (2 to 4 yrs.):									
Operated	85		43%	14%	7%	12%			17%
Not operated	58		4%	4%	4%	42%			35%

NOTATIONS

Same as tables 1 and 2.
Arrested cases include all the practical cures and all greatly improved.
[a] One case in this group was considered a practical cure up to the time of his last illness; in the final tabulation it is counted as a late death. See table 2 No. 9.

cures) and are able to perform a full day's work, four are clinical cures and are able to perform light work. Three are listed as improved; one of these was later re-operated and became a practical cure and is now working as a laborer.

The Wilms-Sauerbruch type of operation should not be lost sight of; it may be employed to good advantage, supplemented by antero-lateral thoracoplasty,[13] for poor risk patients who have extensive tuberculosis with cavitation involving two-thirds or more of one lung. However, it will be seldom indicated, as the more limited type of operation to be described is more conservative and entirely effective for the great majority of patients who require thoracoplasty.

The modified Brauer thoracoplasty is the operation which is generally being employed today. It is a selective type of collapse which affects the involved part of the lung and leaves the healthy part to function freely. It involves a resection of from three to nine ribs, according to the degree of downward extension of the disease. The first two ribs and their cartilages are removed completely; the third rib is removed completely on the right side but only up to the nipple line on the left side. When additional ribs require removal they are resected from the spine to about the anterior axillary line. The transverse processes are usually also resected. The collapse is accomplished in stages; no more than three ribs are now resected at any one stage. If this rule is strictly adhered to, the mortality will be very low. Thus, in a series of 24 patients managed by this method, only one death occurred following an operation limited to the resection of three ribs. (Table 2.) The three other deaths in this series followed stages in which five, five, and four ribs, respectively, were removed. These occurred during the transition period when the old type operation was being superseded by the new type, before it was definitely recognized that it is hazardous to attack too many ribs at one time when wide excisions are practiced.

*Thoracoplasty combined with extrafascial pneumolysis** will henceforth be the operation most frequently employed whenever a plastic collapse is indicated. In this operation, which was recently described by Carl Semb of Oslo,[15] the entire first

*Lilienthal[14] has for many years made use of a similar method which has been very effective.

and second ribs and a large section of the third are removed. The uppermost intercostal bundles are severed from near their spinal attachments. A plane of cleavage is then detected outside of the parietal pleura and the entire apex of the lung is freed from its anchorage all around. This mobilization can be extended downward as far as the root of the lung when necessary. When dealing with large cavities, the transverse processes are also removed. If additional collapse is required the subjacent ribs are dealt with in the usual manner always remembering not to resect more than three ribs at any one stage.

This operation promises to be accompanied by a low mortality and to result in a relatively high percentage of clinical cures. The necessity for reoperation and supplemental operations will be rare. A one stage, 3 rib resection will be sufficient for many patients who heretofore would have required two stages with resection of five ribs; likewise, a two stage, five or six rib excision will probably suffice in lieu of the two or three stages of six to nine ribs previously required to effect the same degree of collapse. The reason for this is apparent when one considers the importance of the cavity and of bringing about its closure in order to accomplish a cure. The older procedures collapsed the chest wall essentially toward the mediastinum; the cavity often remained open because it was still suspended through its extrapleural connections to the spine, the dome of the thorax, and the mediastinum. No degree of thoracoplastic collapse alone was able to accomplish closure of some cavities. The combined operation, however, brings about collapse from above downward and releases the moorings from all surfaces of the apex so that this portion of the lung and its contained cavity may retract concentrically. Adding extrapleural pneumolysis in this manner to thoracoplasty, accomplishes for the average thoracoplasty what intrapleural pneumolysis does for the suspended cavity in pneumothorax with adhesions. More than that, it anticipates the suspended cavity and prevents it from being an embarrassing element following an otherwise efficiently performed thoracoplasty.

Three patients have been managed by this combined method. Two of these had had previous thoracoplasty and presented the typical suspended cavity near the mediastinum. Only a one stage operation was required in each. One patient has lost all sputum and is on the road to becoming a practical cure. The second patient remains unimproved. The third patient managed by this method is still under surgical supervision; she has already lost all sputum and will not require any further operation beyond the three rib resection which she has already had. (Table 3.)

Summary

1. The importance of the cavity and of bringing about its closure in the management of pulmonary tuberculosis has been stressed.

2. Efficient methods of surgical collapse which are available when other methods fail have been described; their beneficent possibilities have been suggested; and their application should not be unduly delayed when definitely indicated.

3. The author's experiences with intrapleural pneumolysis, "plombage," the Wilms-Sauerbruch thoracoplasty, the modified Brauer thoracoplasty, and the newer combined operation of Semb have been noted briefly.

4. The strict rule of not removing more than three ribs in any one stage in thoracoplasty requiring wide rib excisions, has been strikingly emphasized by the author's own experience. Only one of the four deaths which occurred in 46 thoracoplasties (92 stages in 42 patients) followed an operation in which this rule was adhered to.

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Discussion

Dr. Joseph C. O'Connell: I have been very much interested in Dr. Windsberg's paper which I think is very concise, yet comprehensive, and shows a considerable knowledge of, and experience with, this very interesting and important branch of surgery. My own experience with this work has been of much more recent date, but what I have seen and done has convinced me of the great value of these surgical procedures in properly selected cases of tuberculosis. In the selection of cases I feel that consultation by the surgeon and a specialist in tuberculosis, who has had for some time supervision of the case to be considered, is of importance, as I feel that it is very necessary that the patient should have been under observation for some time, and at least holding his own under treatment. I think that a case which has been going down hill, under treatment, is not suitable for operative interference. The author has brought to our attention the various procedures: Pneumothorax, Intra pleural pneumolysis, Extra pleural apicolysis and Plombage; Operations on the phrenic nerve and the various types of Thorocoplasty. He has also shown the advance made in this latter procedure. He shows that he has had a considerable experience in this work and I believe that the results, as shown by his charts, compare very favorably with those of other men who have been doing a great deal of this work. He has also shown by his charts a considerable lessening of mortality in cases with cavity formation following surgery, over that of similar cases treated entirely medically. I believe that surgery should almost always be limited to the cases of the productive type with cavity formation. Of these procedures mentioned, first in the order of importance and frequency, we must place pneumothorax, augmented at times with intra pleural pneumolysis, which will often change unsatisfactory to satisfactory cases. However, I believe that if a case proves unsatisfactory, the method should not be persisted in for too long a time. I think that phrenic nerve operations may be of great importance as an auxiliary method in the treatment of the first group of cases; when successful, proving of great value, but unfortunately the desired results are not always obtained. In these unsuccessful cases I believe that the poor result is often due to the fact that the phrenic nerve may be made up of several branches which may unite lower than the usual seat of phrenicectomy. If this is borne in mind and a more radical operation on the nerve is performed, either by severing the several branches or probably by avulsion of a long segment of the nerve, the results are apt to be all that one may desire. I believe, as Dr. Windsberg has stated, that the combined operation of Dr. Semb is a great improvement over the older methods such as the modified Brauer or Sauerbruch operation, as in the older operations it was necessary to collapse and put out of commission a whole lung, whereas under the newer type of operation, that portion of the lung containing the cavity may be collapsed, allowing the normal part of the lung to function. I think, however, that there may be some danger of activating the process in the lung by the added manipulation necessary. I believe that the author's observation on the limitation of operation to three ribs at each sitting, is also very good, although the removal of good sized sections of five or six ribs, apparently, at times gives rise to no unfavorable symptoms. However, if more ribs are removed the intervals between steps of the operation must usually be made longer and the patient's stay in the hospital is usually not shortened. Since having had some experience in this work I have been very much impressed by the fact that the operation, which I, and I believe many of us had considered a very shocking and mutilating operation accompanied by great dangers, is not particularly hard on the patient and is usually followed by a quite comfortable convalescence after the first few days; is not mutilating and is the source of a great deal of satisfaction to the patient, who usually takes a new outlook on life, and looks forward to a cure of which he had hitherto had no hope. I believe that the use of cyclo-propane, as an anæsthetic, greatly reduces the shock to the patient and is an important cause in the lessening of mortality. I wish to congratulate Dr. Windsberg on his paper and on the good work which he has been doing in this line.

Dr. J. Murray Beardsley: I would like to congratulate Dr. Windsberg on his very excellent paper. There are only two points upon which I might comment. He stated that his policy with regard to phrenic nerve operation was to do a crushing and if a beneficial result were obtained at the end of six weeks, he then did a phrenic exoresis. After doing a phrenic crushing I wait six months or until such time as returning diaphragmatic motion is noted. I will then probably repeat the crushing once or twice, depending upon the indication at that time—the point being that with pulmonary tuberculosis we must consider the disease as a whole and remember the possibility of later trouble developing in the oppostie lung the treatment of which might be handicapped by the diminished vital capacity resulting from a permanently elevated diaphragm, if the indication for collapse therapy did exist on that side. With regard to limiting the operation of thoracoplasty to three ribs at all times—I have removed four ribs in the second stage operation when I felt the condition of the patient was good. The idea of limiting the operation is to shorten the time and to avoid shock, and it has been my experience that as a rule the first stage with the removal of three ribs is more time consuming and shocking than the second stage with the removal of four. I feel, also, that the collapse is augmented by a falling in of the scapula which is accomplished by a removal of the seventh rib.

Dr. Windsberg: In regard to phrenic nerve paralysis no definite rules can possibly include all situations. Each patient's case has to be individualized to determine when, if at all, a temporary paralysis should be converted into one which is permanent. What Dr. Beardsley stated is for general purposes an excellent guide. In this presentation the author was concerned especially with the problem of the closure of the cavity in pulmonary tuberculosis. It seems reasonable that when a cavity has closed following a temporary paralysis no undue time should be allowed to go by before the paralysis is made permanent. When wide rib excisions are practiced, it is especially in the second stage of the operation, the author emphasizes, that it is dangerous to deal with more than three ribs at a single sitting. It is here that a relatively large expanse of chest wall is left unprotected by each rib removed, and that the danger of paradoxical respiration due to a "soft" chest wall is to be feared. This is true to a lesser degree during the first stage because of the protection afforded by the scapula and the relatively smaller area of chest wall left "bare" by each rib removed. If the seventh rib requires removal it is more safely accomplished at a third sitting as a minor procedure under local anæsthesia. The mortality in any large series will be definitely lower if one approaches the operation with the question: "Shall I deal with three ribs or less than three." The converse of this is also true.

THE REORGANIZED STATE DEPARTMENT OF HEALTH

Edward A. McLaughlin, M.D.
Rhode Island Department of Public Health

The Administrative Code Act, passed in January and amended in May, 1935, so reorganized the entire State government that the powers and duties previously distributed among the numerous State administrative agencies were vested in eleven departments: The Governor, Secretary of State, Attorney-General, General Treasurer, Director of Public Welfare, Director of Public Works, Director of Taxation, Director of Education, Director of Labor, Director of Agriculture and Conservation, and Director of Public Health. This Reorganization Bill replaced the Rhode Island Public Health Commission, which had five members, with a Director of the Department of Public Health. In this Department were placed the following Divisions: Sanitary Inspection, Narcotic Drugs and Pharmacy, Purification of Waters, Foods and Drugs, Athletics and Examiners.

In the Department of Public Health, the Division of Administration, which might be termed the Main Office, does the adminstrative work for the whole Department. This includes preparing the budget, making out payrolls, supervision of revenue and the licensing of barbers, hairdressers, chiropodists and dentists. The Main Office supervises the purchase and distribution of all biological materials and of all purchases made in the Department. In the Division of Administration are the Bureaus of Maternal and Child Health and of Preventable Diseases. This latter bureau combines the work formerly done by the Venereal Disease Division and the Division of Epidemiology, and also Supervises rural health and the District Health Units, made possible with Federal funds. Under the Social Security Act, for the fiscal year ending June 30, 1937, $55,633.00 was granted by the U. S. Public Health Service to expand public health services in the State of Rhode Island. This was Rhode Island's share in an $8,000,000 appropriation, based on the amount of money already expended for public health work in Rhode Island and on population. We were fortunate in obtaining all the money that Rhode Island could get under this Section. These funds were used partly for training four physicians in public health work, for five sanitarians and six nurses. These individuals were trained at the Massachusetts Institute of Technology and at Columbia University. A part of the funds were used to strengthen the Central Administration and with the balance the salaries of those employed in the District Health Units were paid. District Health Units were set up in Woonsocket, in Bristol and in Peacedale. Each of these units consists of a health officer, a sanitarian, a public health nurse and a clerk. The units are branches of the State Department of Public Health and offer a complete full-time local health service, cooperating with the local health workers. By this decentralization of the State health service, allowing closer contact with local communities, we hope to provide a much more efficient health service for all parts of the State. The units will not engage in the practice of medicine nor will they take work away from practicing physicians or from other health or welfare workers. The aim is to assist such existing agencies as physicians, nursing organizations, parent teachers associations and local health officers. By this assistance it is hoped to increase the value to the community of the services rendered by these agencies which have already demonstrated their worth as essential parts of the community's life. Such units serve a purely public health function in prevention of disease, prolongation of life and lessening of physical and mental deficiencies, through organized community effort.

In the Preventable Disease Division, the present Surgeon-General, Dr. Parran, has started an intensive program for the control of syphilis and gonorrhea. In order to successfully control these diseases we must have the cooperation of the private physicians. The State Department of Public Health is required by law to immediately use every available means to locate persons infected or suspected of being infected with venereal disease and to ascertain the source of such infections. The State Department of Public Health is invested with full powers of inspection and examination. Bear in mind that by law the information submitted by you must be held secret. The law requires any physician who treats a case of venereal disease to make a report of such case, by name or by separate number, to the State Board of Public Health. I earnestly request your cooperation in this and ask you to inform the State Department when your patient ceases to continue treatment with you, if he

Read before the Providence Medical Association at the Ninety-first Annual Meeting, Providence, January 4, 1937.

is still in the infectious stage. Only by following up the infectious delinquents can we hope to prevent the spread of these diseases. At the present time the State Department of Health supplies free medicine to clinics. We hope in the very near future to find sufficient money to supply arsenicals and other anti-syphilitic medicines free to the private physician. The State Department of Health stands ever ready to help the private physician in this work and at no time intends to take cases away from him.

In the Administrative Division there is also a sub-division of Industrial Hygiene set up this year by legislative act: 1. To make studies of industrial hygiene and occupational disease problems in industry; 2. to recommend to the legislature for enactment such measures as its studies and experience may demonstrate to be advisable and (3) to keep complete records of its studies, recommendations and other activities. The sub-divisions of Industrial Hygiene was made possible by an appropriation of $11,500 by the State, matched with an equal amount appropriated by the Federal Government. In addition to this the Federal Government provided $6,300 for the necessary laboratory equipment. Occupational diseases which come to your attention are reportable by law. I ask your cooperation in this matter. After September 15, 1936 the Compensation Law provides a maximum of $200.00 instead of $100.00 for medical services to an injured employee and $250.00 instead of $150.00 for the same services when more than 14 days hospitalization is needed. There is now no time limit for the length of service, which formerly was eight weeks.

Under the Social Security Act the State receives dollar for dollar for money spent for the promotion of maternal and child health. For the present fiscal year, which ends June 30, 1937, $33,783.00 was appropriated by the Federal Government to match an equal amount to be spent by the State. With this increased amount, nursing services have been extended to parts of the State not previously covered because of lack of funds. It provides for an assistant physician in charge of child health, for another to assist in clinic work, for more nurses, for dental education and for increased clerical assistance and necessary equipment.

Financial aid to the State is received under another title of the Social Security Act, administered by the Children's Bureau in the Department of Labor and is entirely apart from the funds received through the Public Health Service. With the aid of this fund a program of experimental immunization against whooping cough with Sauer's Vaccine has been instituted. The program calls for the immunization of groups of children under the age of five, in several communities, with a control group not immunized. As far as possible only those are immunized who are financially unable to have the services of a private physician, children whose parents bring them to outpatient clinics when they have any sickness. We try hard to avoid including in this group any child who comes to a private physician when sick, so that there may be no encroachment on the work of the private physician. It is hoped by this program to obtain definite information within a year or two as to the efficiency of this vaccine in the prevention of whooping cough. With Federal Funds a program to find incipient tuberculosis in children of high school age has been started. Positive cases are referred to the family physician for follow-up and a letter sent him as to our findings. These two important public health projects will eventually provide more work for the private physician and in no way encroach upon him.

In the Division of Maternal and Child Health there is a Crippled Children's Sub-Division, financed by $5,000 appropriated by the State with an equal amount from the Federal Government, for the purpose of locating and providing necessary services for crippled children under the age of 21. This work consists in providing the necessary hospital care and braces for those in economic distress. This is the first time in the history of the State that money has been appropriated by the State for aid to crippled children. The amount appropriated is small compared with the amount available to the State from the Federal Grant. It is hoped that hospitals which have been doing free work for crippled children in the past will somehow be reimbursed from Federal money as they continue this work. There will be about $40,000 so available after July 1st, which the State cannot match, but which could be matched by private funds. None of this money will be used for the hospitalization of crippled children who are under the care of a private physician or who can afford to pay a private physician. I hope that some way may be found to reimburse physicians as well as hospitals for the care of those crippled children in

their practice for which they are not already sufficiently paid.

The Laboratory Division comprises the following laboratories: Pathological, Bacteriological, Chemical, Toxicological and Food. The work of the laboratory division has increased greatly in the past year. This division stands ready to serve the physician at any time. Replies to the questionnaire sent out to physicians early last year, regarding the laboratory services which had been suspended, showed that 188 physicians desired to have surgical specimens examined, 437 requested blood examinations and 288 requested urine examinations. Because of these requests funds were provided to again render this service. It is understood that this service is only for those patients who in your opinion cannot afford to have work done in private laboratories. The laboratory provides day and night service. By contacting Mr. Edgar Staff at his home, emergency service will be provided, especially the Neufeld Test for pneumonia typing.

The Division of Vital Statistics continues to carry on the same work as formerly, recording the returns of births, deaths and marriages and transcribing the same to the Bureau of the Census at Washington.

The new Division of Sanitary Inspection is empowered to enforce the provisions of all general and public laws relating to the inspection of swimming pools, bathing beaches, camp grounds, barber shops, hairdressing parlors, eating and drinking places and other premises and properties of which the sanitation pertains to public health.

The Division of Narcotic Drugs and Pharmacies combines the work of two former boards, the Narcotic Board and the Pharmacy Board. This division enforces the Uniform Narcotic Drug Act. The law is very strict in regard to narcotic drugs but the Division of Narcotic Drugs and Pharmacy has not annoyed the physicians in keeping to the strict letter of the law because we feel that the registered physician acts in good faith and makes no attempt to violate the main purpose of the law. The law provides that a physician shall not prescribe or dispense a hypodermic syringe or needle without first having issued an official permit for the same on blanks furnished by this division and available upon request. This division also supervises the licensing and inspection of drug stores.

The Division of Purification of Waters replaces the old Board of Purification of Waters and performs the work formerly done by that Board. The function of this division is to prevent stream pollution by sewage or industrial wastes. It frequently tests the streams and rivers, traces the source of pollution found and corrects the same, whether caused by individuals, industrial plants or town or city sewage plants.

The Division of Foods and Drugs replaces the former Board of Food and Drug Commissioners. The Food and Drug law covers a very broad field, related to the purity of food and drugs, false advertising, misrepresentation, misbranding and the like. Samples collected by the food and drug inspectors are tested in the food laboratory, now a part of the general laboratory. The work of this division is extensive. Frequently foods are ordered destroyed because they have become spoiled or are dangerous for human consumption.

The Division of Athletics replaces the former State Athletic Commission. The function of this division is to supervise professional and amateur boxing and wrestling matches.

The Division of Examiners is a new division set up by the Reorganization Bill. Do not confuse it with the medical examiners, appointed by the Attorney-General and under his supervision. The Division of Examiners comprises eleven Boards of Examiners, performing the duties of the former boards of examiners in the examination of new applicants for the various arts and professions. It is interesting to note how the work of some of the former boards has now been divided. Formerly the Board of Barber Examiners had full control of the barber trade. The licensing is now done by the Division of Administration, the inspection by the Division of Sanitary Inspection and the examinations are now given by the three-man Board of Examiners in Barbering. A similar change applies to several other Boards, which formerly had full power over their particular art or profession.

In closing, I ask you to cooperate with the State Department of Public Health, which stands ever ready to serve you. I assure you that the State Department of Health will never encroach upon the private physician but hopes by these various programs to provide more, rather than less work for the private physician. We hope to interest the people of the State in "Public Health."

THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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WARFARE AGAINST CANCER

This month (March) has been selected by the Women's Field Army of the American Society for the Control of Cancer as the time to launch a nationwide campaign of lay education in cancer. For something over a year this campaign has been in the making, sponsored by the American Federation of Women's Clubs together with the American Society for the Control of Cancer. The first organization contributes the zeal and devoted interest of a large group of women who have recognized the modern menace of cancer and have determined to do something about it; the second provides a scientific body whose special function is the collection of cancer facts and the getting of them into the best possible form for educational presentation. Working together through national, state, and local committees these organizations have evolved their Women's Field Army, enlisting the aid of the state and local medical societies and health commissions. The special aid required of the State Medical Society is to supply speakers and this function it is preparing to fulfill through its Cancer Committee which has recently solicited names of volunteers from the various local societies. The list will be available to the community from which a call comes.

There can be no doubt of the great force behind this movement. It is the spontaneous revolt of a large body of American womanhood against the increasing menace of cancer. These women want the facts about cancer and they want their relatives and neighbors to have them, and if early recognition and proper treatment, instituted early, is the only present known way to combat cancer and to cut down the number of its victims, then they want to know how they can recognize early symptoms and signs, and how they can get the benefit of the best that the community affords in diagnosis and treatment.

Obviously any such program of enlightenment must stand or fall eventually on the reception it receives from the medical profession. Some of us will think, as in the past many have, that such campaigns fill patients' minds with useless fears and make some of our neurotics harder to deal with, giving them new possibilities to worry about. We must not let the possible harm to a relatively few such neurotics outweigh the great good that such a campaign will do for the great body of healthy-minded people. For it is now amply proven (1) that success in cancer treatment is almost directly proportional to the stage of advancement in which the cancer is found, when first seen by a competent physician, and (2) that only through *lay publicity* can the patient be taught to recognize symptoms and signs early enough, and be given the encouragement necessary to get him to submit early to treatment.

Others of us, in our reception of patients that come to us as a result of this campaign, may do great good or harm. If such a patient comes to us, let us hear his story, make a careful examination, and if we do not think his lesion to be cancer, let us not make light of this finding and take the occasion to tell him to forget about it. Let us congratulate him that he has had the good sense to be suspicious and to come for reassurance. Let us take the occasion to further educate him and send him out to preach the gospel to his friends. One of his friends may turn up with a lesion that is an early cancer.

Let us all lend the weight of our influence and our knowledge to this nationwide effort. Let us give our time as speakers and last but not least let us give patients who come to us with minor ailments, after being educated, careful and thorough attention, impressing upon them our belief in the value of this teaching, for the authority of *their own doctor* after all means more than anything they hear from the lecture platform. The fight against cancer is a fight against ignorance and fear. The Women's Field Army is bringing its force to bear to overcome ignorance and fear with knowledge. Let us give whole-heartedly of our time and influence to "*hold up their hands*" and make their campaign a success.

RHODE ISLAND MEDICAL SOCIETY

Program of Sunday Health Talks

Submitted by the Committee on Education, Russell S. Bray, M.D., Chairman

Because of a nation wide hook-up, WPRO has found it impossible to arrange a satisfactory time for our local Sunday broadcast. Therefore, feeling that there are greater advantages to be gained through an informal contact with a representative audience, it was decided to cancel the broadcast of the present series of lectures.

The lectures will be given as usual on Sunday afternoons at 3:30 o'clock during the month of March.

Speakers:

March 7th. Drs. Herman C. Pitts and James A. McCann, "Cancer — Facts and Fancies."

March 14th. Drs. Charles S. Christie and D. V. Troppoli, "Headache — Medical and Surgical Aspects."

March 21st. Dr. Charles F. Gormly, "How to Grow Old Gracefully." Dr. Henry L. C. Weyler, "Why Poison Yourself — The Nostrum Evil."

March 28. Drs. Alfred L. Potter and David R. Brodsky, "Modern Trends in Obstetrics."

RHODE ISLAND MEDICAL SOCIETY

Meeting of the Council

January 21, 1937

The January meeting of the Council was called to order by the President, Dr. John E. Donley, in the Medical Library Building, at 4 P. M.

Dr. Mowry moved that the name of Dr. Edgar B. Smith be placed on the retired list. The motion was carried. Dr. Mowry then moved that the name of Dr. Frederick N. Brown be placed on the retired list. The motion was carried.

Dr. Mowry reported that certain bonds owned by the Society had been called and discussed the use to which the proceeds of these bonds should be put. He suggested the investment of the beforementioned proceeds in high grade common stocks, always keeping in mind that safety of the principle is the first consideration. Dr. Hammond moved that the Treasurer be given authority to invest the money obtained from the sale of the called bonds in high grade common stocks along the line of diversification which Dr. Mowry described. The motion was seconded and unanimously approved.

Dr. Holt raised the question of advisability of encouraging District Societies to require their members to join the State Medical Society. Dr. Mowry moved that the Council deems it inadvisable at the present time to advise the District Societies to drop any member from their rolls because he has not joined the State Society within a given time. It was so decided.

The meeting was adjourned.

Respectfully submitted,

GUY W. WELLS, M.D., *Secretary*

Meeting of the House of Delegates

January 21, 1937

The regular January meeting of the House of Delegates was called to order by the President, Dr. John E. Donley, at 5 P. M.

1. The Secretary made a verbal report of the transactions at the meeting of the Council.

2. The Secretary then reported for the Nominating Committee the name of Dr. Edward S. Brackett for Second Vice President to fill the vacancy created by the death of Dr. James W. Leech.

3. The President then appointed the following to serve as a Nominating Committee for the year 1937:

Dr. Roland Hammond, Providence, Chairman
Dr. John F. Kenney, Pawtucket
Dr. William S. Streker, Providence
Dr. Henri E. Gauthier, Woonsocket
Dr. Linwood H. Johnson, Westerly

4. Dr. Charles L. Farrell discussed the advisability of encouraging members of District Societies to join the Rhode Island Medical Society.

5. It was then moved and approved that each District Society be asked to conduct a campaign in whatsoever way it deemed best to increase the membership of the State Society.

6. The President appointed Dr. Charles Bradley as Chairman of the Publicity Committee.

7. The President reported to the House of Delegates the appointments of delegates to New England Medical Societies which he had made at the December meeting of the Society. The meeting was then adjourned.

Respectfully submitted,

GUY W. WELLS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the February Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Peter Pineo Chase, on Monday, February 1, at 8:30 P. M. The minutes of the last meeting were read and approved.

The Secretary read a communication from Dr. Herman C. Pitts, Chairman of the Cancer Committee of the Rhode Island Medical Society, asking for volunteers to speak at public meetings sponsored by the Women's Field Army of Rhode Island.

Dr. Ira C. Nichols read an obituary on Dr. George E. Clark. It was voted to spread this on the records and to send a copy to the family.

The President announced the appointment of the following committee to study the question of reorganization:

Dr. William S. Streker, Chairman
Dr. Harry C. Messinger
Dr. William P. Buffum
Dr. Frank B. Cutts
Dr. William A. Horan

The first paper of the evening was given by Drs. Chester W. Howe and William J. Bell of the Rhode Island Hospital, and was entitled "Comparative Results of Regular and Protamine Insulin Therapy." The paper was discussed by Drs. Lawson, Greenstein and Kramer.

The second paper was read by Dr. Frank B. Littlefield, and was entitled "Sclerosing Injections as an Adjunct to Surgery." The paper was discussed by Dr. Chase.

The meeting was adjourned at 10:00 P. M. Attendance 89. Collation was served.

Respectfully submitted,
HERMAN A. LAWSON, M.D.,
Secretary.

Report of the Blood Transfusion Bureau

Donors were provided for 79 transfusions. Twenty-five of these 79 cases were charity transfusions; in partial or total payment therefor $215.75 was disbursed from the Charity Fund. This leaves a balance in Savings Account of $1,268.04. The 47 paying cases yielded an income of $117.50. Expenses of $50.05 left a net income for the year of $67.45.

The committee is pleased to report a contribution to the Charity Fund of $25.00 from the Mary Dexter Fund, Inc. The Bureau has now been in operation almost two years and appears to be filling a real need in the community.

Respectfully submitted,
FRANCIS H. CHAFEE, M.D.,
Chairman and Treasurer

PAWTUCKET MEDICAL ASSOCIATION

February Meeting

The regular meeting of the Pawtucket Medical Association was held on February 18, 1937, at the Nurses' Auditorium of the Memorial Hospital.

It was voted that a copy of letter which was sent by Dr. Chas. L. Farrell, chairman of the committee on Public Health Clinics to Dr. Arthur Brown, chairman of the Public Relations Committee of the Providence Medical Association, be mailed to each member of the association.

Pawtucket Medical Association went on record as opposed to the activities of Dr. John Pickney in extension of his diagnostic service to Child's Restaurants. It was further voted that the Secretary write to the Secretary of each district society notifying him of the action of the Pawtucket Medical Association.

The secretary was instructed to contact each member of the Pawtucket Medical Association to accept a speakers appointment on cancer as requested by Dr. Herman C. Pitts, chairman of the Cancer Committee.

Dr. Charles L. Farrell was given a vote of appreciation for the good work he is doing as chairman of the Public Health Clinics. The Pawtucket Medical Association voted that in the future only the President of the State Medical Society be the invited guest at the annual banquet.

A list of the nominations for 1937 and 1938 was presented by the nominating committee, the officers to be Dr. Edward Cormier, President; Dr. Charles L. Farrell, Vice President; Dr. Earl Mara, Treasurer and Dr. Thad A. Krolicki, Secretary.

Mr. Carleton Sawyer was the speaker of the evening and spoke on the growing and manufacture of tobacco, and of the influence of cigarette smoking on mucous membranes.

The collation served. Meeting adjourned at 11:45 P. M.

THAD A. KROLICKI, M.D.
Secretary

NEWPORT MEDICAL SOCIETY

January Meeting

At the Annual Meeting of the Newport County Medical Society, held on January 26, 1937, the following officers were elected:—

President, Dr. Philip E. Clark
First Vice-President, Dr. James C. Callahan
Second Vice-President, Dr. Alfred M. Tartaglino
Secretary, Dr. Samuel Edelson

Delegates to the Rhode Island Medical Society,
Dr. Edward V. Murphy,
Dr. Wm. Arthur Stoops
Councilor, Dr. Charles W. Stewart
Censor, Dr. Edward V. Murphy

The President appointed an Executive Committee composed of
Dr. James C. Callahan,
Dr. Phillip S. Geller,
Dr. William M. Redman.

Dr. Eske Windsberg of Providence read a paper on the subject "Some Recent Advances in Thoracic Surgery."

WOONSOCKET DISTRICT MEDICAL SOCIETY

January Meeting

On January 14, 1937, the Woonsocket District Medical Society held its regular meeting at the Lafayette House, Foxboro, Massachusetts. Following a light supper, the guest speaker of the evening, Dr. Charles L. Farrell, of Pawtucket, explained in detail the accomplishments of the Caduceus Club. In spite of the inclement weather, the attendance was very satisfactory. Dr. James McCarthy, Jr., recently elected to the presidency, was in charge. It may be mentioned that Woonsocket had its "Medical Club" in 1929 and in 1930 and that before long, this Medical Club may be resuscitated, or a club similar in outline to the Caduceus Club may be formed.

CHANGE OF ADDRESS

Dr. James P. Clune:
To 156 Auburn Street, Cranston

Dr. Seebert J. Goldowsky:
To 209 Angell Street, Providence

Woonsocket Hospital

Members of the Woonsocket Hospital Staff are very proud of the new X-Ray equipment that was recently installed. Dr. Norman S. Garrison should be commended for his fine selection. This is but a morsel of a carefully planned renovation of the entire hospital. There has been marked improvement in the physio-therapy department, the new obstetrical ward is nearing completion and plans are being sketched for modernization of the present operating rooms, an addition that will add at least two more operating rooms and allow for emergency and utility rooms. These changes and the present enviable financial condition of the Hospital can be attributed to the management and to the liberal response given by the community to the annual appeal for contributions.

Dr. Joseph B. McKenna of Melrose and Tufts Medical College, 1936, is chief interne, being assisted at the present time by junior-interne, Ora Wagman, of Boston and Tufts Medical College, 1937.

The monthly meeting of the Regular Staff was held January 11, 1937, at 11:00 A. M. The President, Dr. T. Frank Kennedy, presided. A motion was made and unanimously approved that the Secretary be instructed to cast one ballot for the present officers, retaining them for the ensuing year. These officers are: President, Dr. T. Frank Kennedy; Vice President, Dr. Henri E. Gauthier; and Secretary-Treasurer, Dr. Thomas J. Lalor. The report from the Medical Board was read and approved. Case Histories were read and discussed. The meeting adjourned at noon.

On January 25, 1937, the monthly Clinical Conference was devoted to the presentation of a case from the Medical Service of Dr. J. H. McCooey, while Dr. V. H. Monti presented a case of Teanus.

Rhode Island Hospital

Dr. F. Charles Hanson of Southbridge, Mass., who interned at the R. I. H., from October, 1933, to October, 1935, and at the Eye and Ear Infirmary in Newark, New Jersey, from February, 1936, to February, 1937, has returned to Providence, intending to do Eye, Ear, Nose and Throat work. Dr. Hanson was graduated from Tufts Medical School in 1933.

Dr. Frederick Stephens' internship at the R. I. H. terminated on January 31st. On February 1st, he entered the Massachusetts Eye and Ear Infirmary

for a period of 26 months. He expects to do Pathological and post-graduate Eye work until June 1st, when he will take up the regular internship. Dr. Stephens secured his B.A. from Syracuse University in 1931 and was graduated from Syracuse Medical School in 1934. Before coming to the R. I. Hospital, he spent four months in the Pathological Department of the Syracuse Memorial Hospital and one month at the Providence Lying-In Hospital.

Dr. Robert Ladd Richards, of Portland, Maine, a graduate of New Hampshire University and Harvard Medical School, 1936, started internship February 15th.

At the Interns' Clinical Pathological Conference, held at the Peters House, February 16th, the case was presented by Dr. William W. Teahan.

The Interns' formal dance and Valentine party, held at the Peters House, February 13th, was a very successful affair with about eighty people present.

St. Joseph's Hospital

The regular monthly meeting of the Staff Association was held at noon on Thursday, February 11. Dr. Alexander Marble of the Joslin Clinic, Boston, gave a talk on "Protamine Insulin." He described the origin and chemistry of protamine insulin and its development at the Joslin Clinic during the past two years. He recommended it as useful in a large group of the cases of diabetes. The discussion was opened by Dr. William S. Streker. Following the meeting, a collation was served. The topic for the meeting on March 11 will be "Amenorrhoea in Relation to Endocrinology."

Open house will be held on Thursdays in the Medical, Neurological and Cardiological Departments. Combined rounds will start in the Out-Patient at 9:30 A. M. and proceed through the wards. All interested physicians are invited to attend and to join in the discussion of cases.

Homeopathic Hospital of Rhode Island

At the meeting of the General Staff held on January 26, the following cases were presented: "Spike Fixation for Femoral Neck Fractures," by Dr. Henry F. McCusker; "Separation of Placenta at Five Months," by Dr. George W. Webster; "Hydrocele and Hernia," by Dr. Edmund A. Sayer.

On February 16, the regular monthly meeting of the General Staff was held at 12:15 P. M. The program: "Head Injuries," by Dr. James H. Fagan; "Eclampsia with Choked Disk," by Drs. George W. Webster and William M. Muncy. Luncheon was served following the meeting.

Minutes of the Caduceus Club

The monthly meeting of the Caduceus Club was held at the T. K. Club, Monday evening, Feb. 8, 1937. The meeting was called to order by the President, Dr. Earl Mara. The report of the Secretary was read and approved. On a motion by Dr. Sprague, it was voted that the Grievance Committee consider the problem of absentee members and the unethical activities of several Physicians in the Community. Following a motion by Dr. Farrell, it was voted that Dr. Stanley Sprague be permitted to address the Kiwanis Club on the subject of Social Disease. Dr. Farrell, Chairman of the Education Committee, reported that the City Officials had granted the Caduceus Club the use of the Senior High Auditorium for the remaining lectures. It was voted that at succeeding monthly meetings there would be a Topic for open discussion by Club Members; the Topic for the next monthly meeting being, The School Health Department in relation to the Local Physician. Following a collation, the meeting was adjourned.

Respectfully submitted,
GEORGE B. MCCLELLAN, M.D.

Local Events

JANUARY 27. The Annual Banquet of the Jacobi Medical Club was held at the Narragansett Hotel and attended by members and their wives. Dr. Abraham Myerson, Professor of Psychiatry at Harvard and Tufts Medical School, gave an interesting talk on "The Common Neuroses."

FEBRUARY 2. The Rhode Island Chapter of the National Society for the Advancement of Gastroenterology was organized at a meeting attended by Drs. Frederick V. Hussey, Arthur T. Jones, Nathaniel H. Gifford, Isaac Gerber, John F. Kenney, Guy W. Wells, Elihu Wing, John E. Donley, Jesse P. Eddy, Frank A. Cummings.

Officers elected were as follows:

President, Dr. Frank Anthony Cummings,
Vice President, Dr. John F. Kenney,
Secretary-Treasurer, Dr. Jesse P. Eddy.

Executive Committee, the officers and
Dr. Frederick V. Hussey,
Dr. Elihu Wing.
Program Committee,
Dr. Guy W. Wells,
Dr. John E. Donley.

It is planned to hold a meeting during May to which all members of the State Society will be invited.

FEBRUARY 12. The William W. Keen Medical Club was entertained by Dr. Alfred L. Potter. Dr. Wilfred Pickles presented a paper on the "History of the Medical School in Brown University."

FEBRUARY 15. At the meeting of the Thirty-four Medical Club, Dr. Clifton B. Leech spoke on "Acute Heart Failure."

FEBRUARY 19. Before the Friday Night Medical Club, Dr. Edward S. Brackett read a paper on "Maternal Deaths at the Providence Lying-In Hospital," a statistical study of the results achieved at the institution during the past three years.

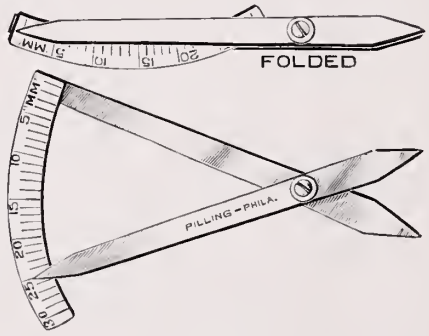
AN INSTRUMENT FOR FACILITATION OF THE TWO-POINT DISCRIMINATION TEST

Ira C. Nichols, M.D.
Butler Hospital, Providence, R. I.

There is a test that should be a part of every complete neurological examination, which is frequently neglected due to the fact that no really adequate instrument for its performance is available. I refer to the two-point discrimination test.

Compasses may be used for this test but it is hard to take off the measurements obtained. There are also several instruments available which combine a two-point tester with other instruments, but these like the proverbial Jack of all trades are masters of none.

The instrument which I have designed is constructed specifically for this purpose. Its chief advantage is that it carries its own scale so that a reading may be taken off directly without applying the points to a rule, which is in practice a time consuming process. A further advantage is that the instrument is constructed on the principle of the draughtsman's proportional dividers so that the distance between the points is magnified on the scale, thereby facilitating the taking off of readings. The instrument is so designed that the ratio of the length of the arm on one side of the pivot is to the length of the arm on the other side as 1:2.5. The measurements, therefore, are multiplied in direct proportion. The instrument may be folded for ease in carrying.



It occurs to the writer that this instrument might be very useful in many special tasks, such as recording measurements for electrocardiographic films, kymograph records, or in short, wherever many determinations of distances under 30 mm. must be made.

I wish to express thanks to Mr. Carl Stickney of Butler Hospital and to the technical staff of the manufacturer for their assistance in bringing my idea forth in concrete form. The instrument is available through the George P. Pilling & Son Co., Philadelphia.

OBITUARY

EDWARD J. LOGAN, M.D.

Dr. Edward J. Logan died at his home, 1171 Westminster Street, April 8, 1936, after a year's illness, mourned by a host of friends and a greater number of patients whose medical, economic, and social adviser he had been for many years. Dr. Logan had been a general practitioner in the City of Providence from 1903 to 1935 when through failing health he was obliged to give up an extensive practice.

Dr. Logan was born in the town of Hampton, Connecticut, the son of Edward and Catherine Logan. At an early age, the family came to Providence where the son attended the grade schools and Mowry Academy. He was graduated from Jefferson Medical College in Philadelphia in May 1903, and licensed to practice in Rhode Island in July 1903.

In April 1917 he married Alice E. Guest who survives him. The scanty leisure that the demands of a general practice permitted him was given to his two hobbies, gardening on a small country place in Scituate, and, in the earlier years, boating and fishing in the waters about Matunuck in South County.

He was a member of the Associate Staffs of St. Joseph's and Homeopathic Hospitals, a Fellow of the American and Rhode Island Medical Associations. His social clubs were the Elks and the Knights of Columbus.

FRED A. COUGHLIN, M.D.
J. JOSEPH HOEY, M.D.

JAMES W. LEECH, M.D.

On October 6, 1936, Dr. James William Leech, while attending a private patient at the Jane Frances Brown Memorial Hospital, sank to the floor unconscious and pulseless, bringing to a close a life that in the highest meaning of the word, can be said to have been successful.

He was born in Worcester, January 22, 1881, the son of James and Elizabeth Abbot Leech. While he was still a child his family moved to Providence which was his home the remainder of his life. He grew to manhood in a home where probity was esteemed above material things and all his life, true to his early training, he was guided by the highest ideals of personal honor and a keen sense of duty in his relations with his fellow men.

He attended the public schools of Worcester and Providence, graduating from the Classical High School in 1898. He entered Brown University in the class of 1902. After two years of pre-medical study he entered the University of Pennsylvania School of Medicine and graduated in the class of 1904 with the degree of Doctor of Medicine *cum laude,* among the first ten in his class in scholastic standing. On the first day of July of the same year he began a one year service as interne in the Rhode Island Hospital. From that day to the day of his death, a period of thirty-two years, he served that hospital in one capacity after another and always faithfully and well. He was assistant superintendent from 1905 to 1907. On resigning this position he was appointed to the Department of Ophthalmology of the Out-Patient Department. In 1909 he was advanced to the house as Assistant Surgeon and became Surgeon in 1917. This appointment he held at the time of his death.

He graced many other positions of honor and trust. From 1916 to 1936 he was Secretary of the Rhode Island Medical Society and at the time of his death its Second Vice President. He was Past President of this Association, Member of the American Academy of Ophthalmology and Otolaryngology and the New England Ophthalmological Society, Fellow of the American College of Surgeons, Past President of the Rhode Island Ophthalmological and Otological Society, Surgeon-in-Chief, Eye Department, Charles V. Chapin Hospital; Consulting Ophthalmologist to the Providence Lying-In Hospital, Providence; Memorial Hospital, Pawtucket; Westerly (R. I.) Hospital and Consulting Laryngologist to the Butler Hospital.

This enumeration of the positions he held in the medical societies and hospitals of the State gives but a faint idea of the debt the profession owes to his memory.

The service which he rendered the Rhode Island Medical Society as Secretary for twenty years was, if not the most useful, at least the most conspicuous of his public activities. It detracts in no measure from the credit due to the many physicians with whom he cooperated in the work of the Society to say that for the greater part of his term he was the spirit which directed its varied activities and assured a continuity of policy and effort. Calm, impartial and unhurried he worked indefatigably to advance the interest of the Society and, whatever cross currents of personal opinion there may have been within its ranks, to present a united front to the general public. When interviewed by the press, his statements were straightforward and dignified, marked by a happy faculty of knowing not only what to say but what to leave unsaid. The growth of the Society in usefulness to its members and in influence in the State is due in great measure to his unremitting labors, his wisdom and his tact.

His interest in this association whether in office or out was active and sustained.

On resigning his position of assistant superintendent of the Rhode Island Hospital he became associated with Dr. Frederick T. Rogers in the practice of otolaryngology and ophthalmology. That association continued until Dr. Rogers' retirement from active practice. Devoted to his profession and genuinely interested in his patients, he

attracted a large and loyal following who admired and loved his personal qualities as much as they prized his professional skill.

In his personal as well as in his professional life, was he truly successful. He was married in 1909 to Jane Russell of Philadelphia, a sister of a medical school classmate. She, with two children, Mrs. Stephen Williamson of Williamsport, Penn., and James Rogers Leech, a senior of Amherst College, survive him. Respected and beloved by his family, by his patients, his friends and professional colleagues, he died at the peak of his usefulness. To the members of this association who knew him as a colleague and a friend, the memory of his lovable personality and his useful life will be forever fragrant and inspiring.

Edward S. Brackett, M.D.

RECENT BOOKS

Physical Therapeutic Methods in Otolaryngology. By Abraham R. Hollender, M.D., F.A.C.S., pp. 442 with 189 illustrations. Cloth, $5.00. St. Louis, The C. V. Mosby Company, 1937.

This is the best and most practical book on physiotherapy of all kinds as applied to diseases of the ear, nose, throat and head, that I have seen. I would put it in the category of "must" reading for anyone using the various electro- and photo-therapeutic devices in head and neck conditions.

The first section of the book is given over to the description of the various types of currents, lights, and agents used, and gives a fairly clear idea of them, and their mode of action. Conventional, and short wave diathermy are discussed and compared in special chapters by Disraeli Kobak, and the various indications and contra-indications given. There are also chapters on electro-surgery and light therapy, X-ray and radium.

The second part of the book deals in the various diseases of the head and neck, and the means of treatment available. It is not a radical approach to ear, nose, and throat therapy. The author is very sane in his viewpoints, and is not at all dogmatic. He by no means feels that physiotherapy is the best means of treatment of every condition. The sections on electro-surgery of the tonsils should be read by everyone. It is a very sane exposition of its merits and demerits.

There is a very clear discussion of the uses of zinc ionization of the nose for hay fever and other allergic conditions. The chapter of zinc ionization of the ear is by Friel of London, one of the originators of this treatment. All in all, it is a very practical book on physio-therapy. I recommend it both to otologists and general men.

Gordon J. McCurdy, M.D.

The Management of Obstetrical Difficulties. By Paul Titus, M.D., with 314 illustrations including four color plates. The C. V. Mosby Company, St. Louis, 1937. Cloth, $8.50

As the title of this work signifies, and as is further stated in his preface, the special purpose of the author is to give to the student and practitioner of obstetrics a book of reference on management and treatment. Only so much of normal physiology, pathology and etiology of the different phases of the subject as are necessary to explain the rationale of the outlined treatment are given. The style of presentation is clear, logical, forceful and authoritative and the treatment outlined is the author's own, which he has found to be the most effective in his personal experience. Where more than one method of attack on a particular problem has been advocated by differing authorities he has not hesitated to signify his preference.

The result is a volume on treatment which should have a wide appeal to both the younger men who are starting their work in obstetrics and to the older men who wish to brush up a bit on some of the later developments in treatment, e.g. the treatment of toxemias and the use of analgesia, etc.

Dr. Titus, recognizing the close relations of gynecology and obstetrics, has included sections on sterility, postpartum uterine misplacements and their treatment, tumor growths, ectopic pregnancy and electro-surgical coagulation and ionization for postpartem cervicitis.

His instructions are explicit: where illustrations are needed they are plentifully supplied, many of them original; where diet lists or printed instructions or prescriptions to patients seem helpful, he has given them.

Long recognized as a student of pregnancy toxemias, his teachings as to the use of hypertonic glucose solutions are universally accepted and are here given in detail.

Dr. Titus has indeed given us an authoritative and valuable book to which the busy practitioner can turn to find a sound answer to his particular difficulty or to which the student who is desirous of delving more deeply into the subject may turn to find an extensive list of references following each chapter to guide him in his reading.

George W. Waterman, M.D.

The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

—*From the Code of Ethics of the A. M. A.*



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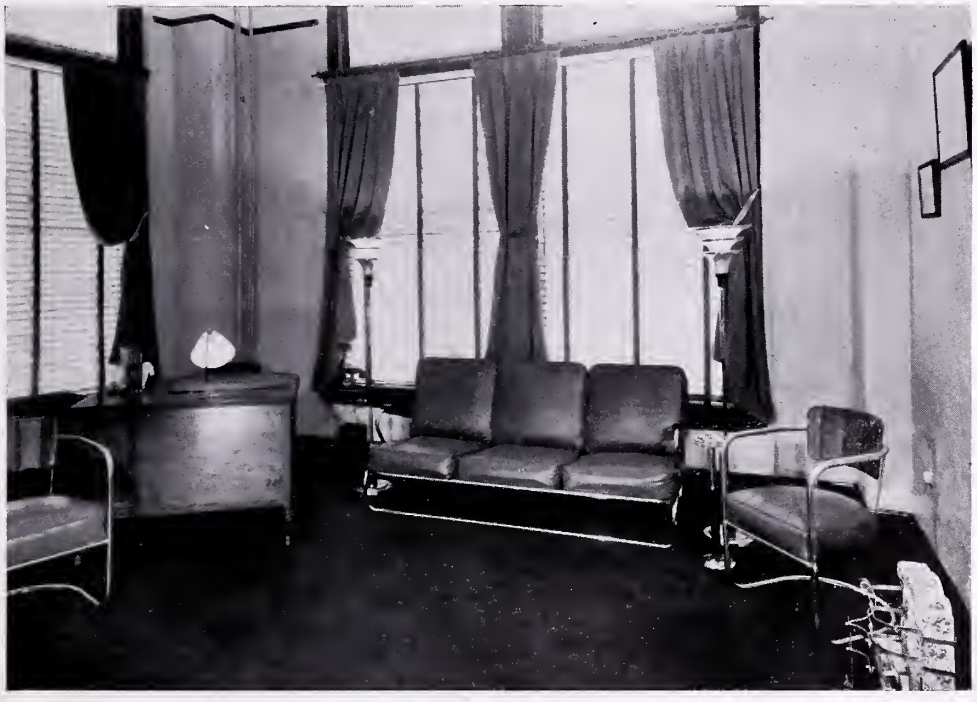
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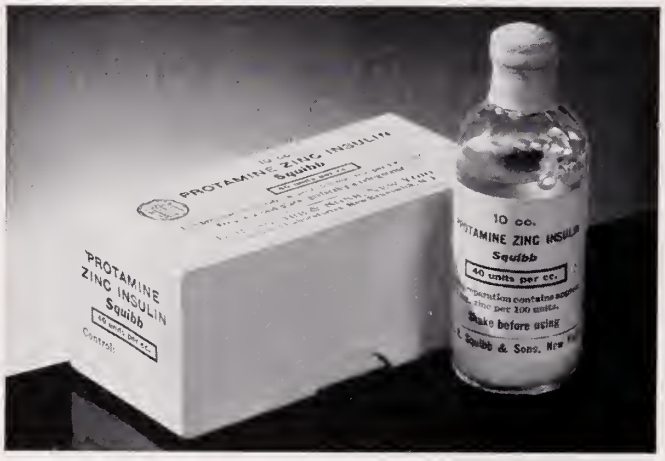
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II. VITAMIN D

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The minimum daily intake which will prevent rickets in infants is probably between 135 and 400 International units of vitamin D as supplied by cod liver oil (1). The optimum prophylactic dose is probably in the neighborhood of 1000 International units (2). It is also interesting to note that the League of Nations Technical Commission has recommended a daily intake of 340 International units of vitamin D for pregnant and lactating women (3).

Irradiated pasteurized milk containing 135 International units per quart and irradiated evaporated milk of the same potency have been found equally effective in preventing rickets in infants. The pediatrician will be interested in the following summary taken from a recent review:

> "Such evidence as is available may be interpreted to show that cod liver oil, cod liver oil concentrate milk, and irradiated milk are of equal potency for the human being, unit for unit." (1-b).

Other than the above recommendation for vitamin D intake during pregnancy and lactation (3), little definite information is available upon which to establish minimum vitamin D requirements of the human after infancy (1), yet while sunlight produces the anti-rachitic factor, most common foods are known to be deficient with respect to vitamin D (4). However, certain foods such as eggs, butter, liver and sea foods do supply this vitamin. The importance of sea foods, especially canned salmon, as carriers of vitamin D has been definitely established. A recent report on the vitamin D content of different varieties of canned salmon gave a value of 1.9 International units per gram for the least potent brand and 6 or more units per gram for several other brands (5).

From a consideration of the vitamin D values of salmon oil, the oil content of canned salmon and the quantity of canned salmon consumed annually in this country, it has been concluded that there is more vitamin D in the canned salmon sold in this country than in the cod liver oil used for both human and animal feeding (6).

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(1) a. 1937. J. Am. Med. Assn. 108, 206
b. 1936. Ibid. 106, 2150
(2) 1936. J. Am. Diet. Assn. 11, 503
(3) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(4) 1935. J. Am. Diet. Assn. 11, 119
(5) 1935. J. Home Econ. 27, 658
(6) 1931. Ind. Eng. Chem. 23, 1066

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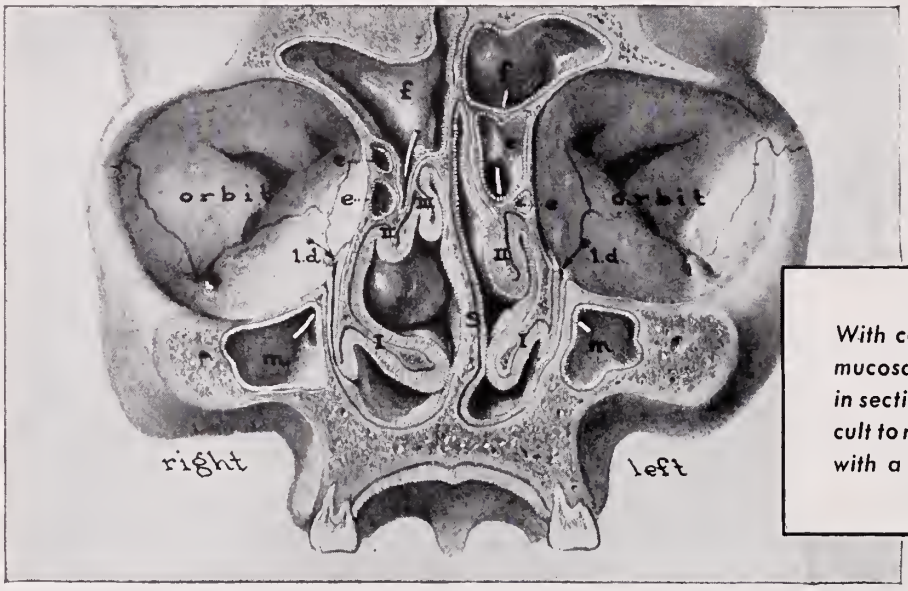
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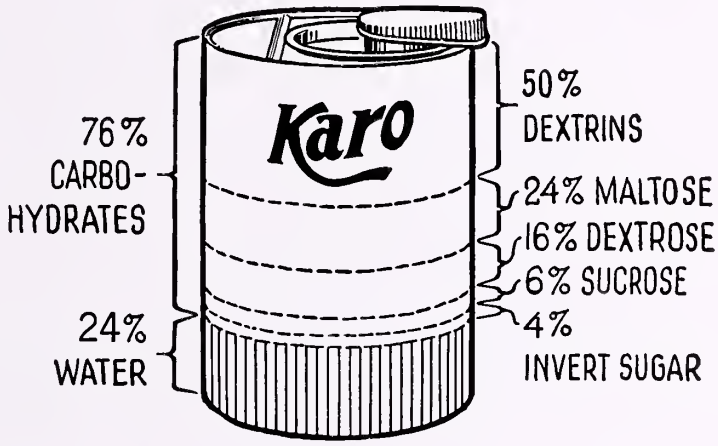
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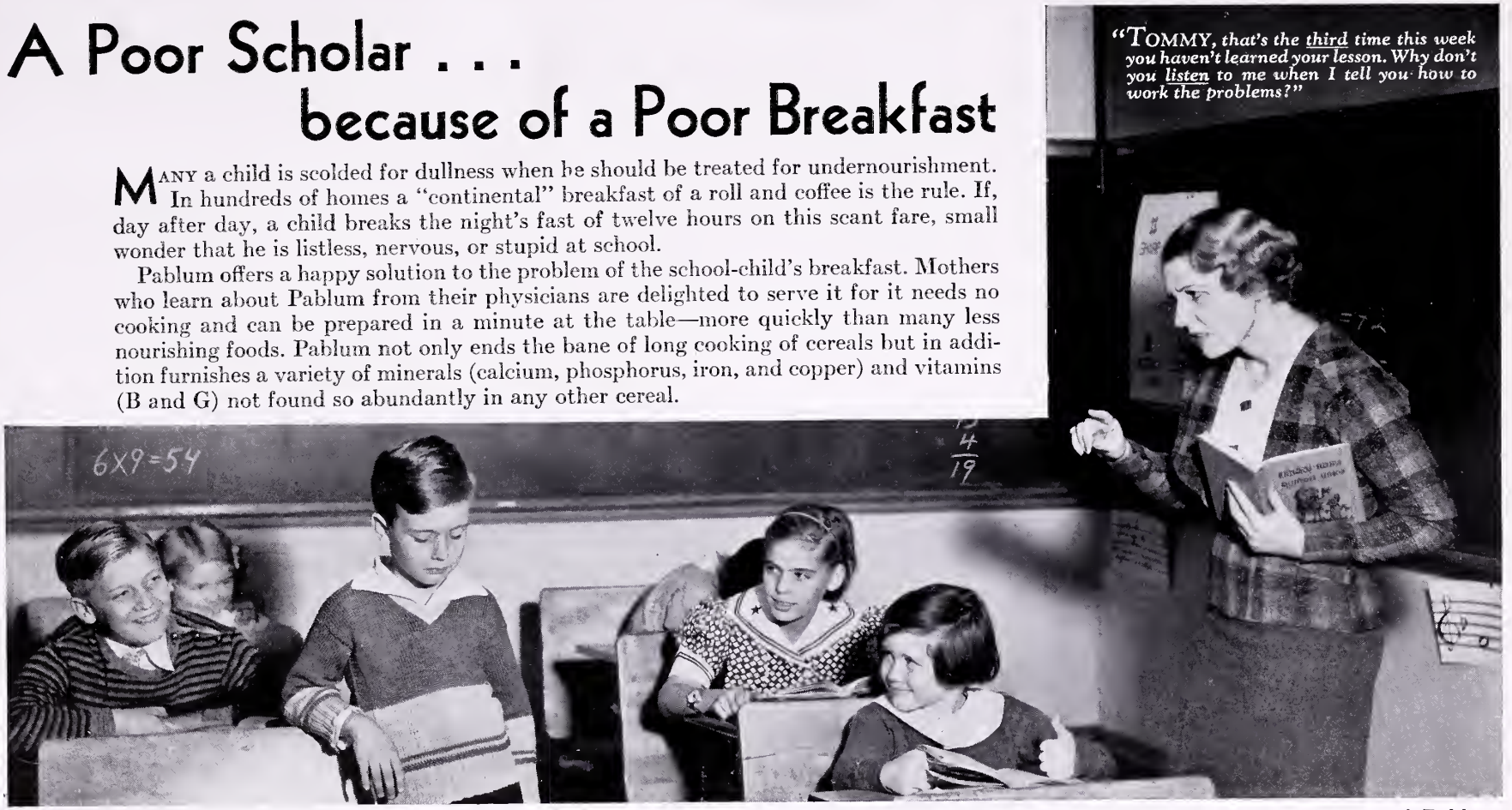
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VOLUME XX / NUMBER 4 | Whole No. 331 | PROVIDENCE, R. I., APRIL, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

EVALUATION OF KIDNEY AND LIVER FUNCTION TESTS

RUSSEL O. BOWMAN, PH.D.

RHODE ISLAND HOSPITAL, PROVIDENCE

The kidney is composed of two physiologically important anatomical parts, the glomerulus and the tubule. The present conception of urinary formation as a filtration and reabsorption process is due, in its present form, largely to the brilliant work of Richards and coworkers[1] of Pennsylvania. Using micro dissection which involved putting a tiny glass pipette into the glomerulus of a frog and collecting glomerular filtrate, Wearn and Richards were able to show that the glomerular filtrate is indeed a filtrate containing all of the diffusible constituents of blood in the same amounts as they are present in plasma and lacking only the non-diffusible plasma constituents such as serum proteins. This filtrate, on passing through the tubule, is subjected to selective reabsorption and, to a certain extent, to secretion. Thus it has been definitely shown that urea and Phenolsulphonphthalein are added to the glomerular filtrate in passage through the tubule while chloride, glucose and water are reabsorbed. Urine, the final product, normally contains no glucose, the same concentration of chloride, sodium, calcium and magnesium, 25 times as much uric acid, 30 times as much phosphate, 40 times as much ammonia, 60 times as much urea, 60 times as much sulphate and 100 times as much creatinine as the blood from which it is formed.

Because of these values urine must represent at least a hundred fold concentration of the glomerular filtrate. Cushny[2] calculated that for the production of the one liter of urine which is normally excreted in 24 hours, the kidneys must be perfused by 67 liters of plasma. The amount of urine passed by any individual varies according to a number of different factors, some of which are water intake, state of hydration of the individual's tissues (edema, serum protein level, etc.) and blood pressure, since blood pressure is, in the last analysis, the mechanism by which the filtrate is formed. It must be formed against a back osmotic pressure, due to the undiffusible serum proteins.

Other than its excretory function the kidney plays a very definite part in nitrogen metabolism. Proteins taken in in foods are absorbed as amino acids after digestion. In the liver these are deaminized, and the ammonia which is split off is changed to urea by the liver, and this urea is excreted by the kidney. Enzymes present in the kidney convert part of the urea to ammonia which is used in combination with acid metabolites to conserve the body's alkaline reserve. Tissue destruction arising from infectious processes, or ordinary break-down of old cells, gives rise to amino acids and urea even in the absence of protein intake. Thus, even in the fasting individual the kidney has work to do.

The nitrogen excreted by the kidney is normally all in the form of non-protein nitrogen (urea, creatinine, uric acid, undetermined nitrogen.) The amount of nitrogen excretion depends on a number of factors, such as dietary intake of nitrogen, urine volume, tissue catabolism, and the physiological condition of the kidney and of the liver. Nitrogen as protein appears in the urine only when the glomerulus is diseased and it becomes permeable to the blood colloids.

Tests of Kidney Function

The more important tests of kidney function are:

1

SPECIFIC GRAVITY:—A morning specimen of urine should show a specific gravity of 1.018 or more, provided no fluids have been taken after the previous evening meal. Lower values than this indicate a lack of concentrating ability of the kidney, provided interfering factors such as loosely held edema and previous diuretics have been ruled out.

2

CONCENTRATION AND DILUTION TESTS:—A more satisfactory test of the kidney's ability to concentrate urine is given by the various forms of concentration and dilution tests. In the Mosenthal test, samples of urine are collected during the day at two hour intervals, and the night specimen from 8 P. M. to 8 A. M. is collected as one more specimen. The specific gravity of the various samples taken during

Read before the December monthly meeting of the Surgical Staff of the Rhode Island Hospital, Friday, December 4, 1936.

the day, while the patient has ordinary meals, should vary by 0.010 from the lowest to the highest. The night specimen should not exceed 400 c.c. in volume and its specific gravity should be at least 1.018. There are various other forms of the concentration and dilution tests which correspond rather closely with the Mosenthal test, dilution being tested by giving 1500 c.c. of water to the fasting patient, after which at least one of the two hour urines should have a specific gravity as low as 1.004.

These tests measure only the water excreting function of the kidney. It is very essential that the patient have no fluid between meals and the tests are interfered with by edema and by the maintenance of abnormally low blood pressure.

3

Phenolsulphonphthalein Excretion: — 1 c.c. of a 0.6% solution of the dye, made slightly basic so that it will be nontoxic, is injected, preferably by the intravenous route, and the dye excretion in the urine is measured for one hour and for two hours after injection of the dye. The normal kidney excretes 40-50% in one, and 60-75% in two hours; an excretion of less than 40% in two hours is indicative of impaired kidney function. This test measures the ability of the kidney to excrete a foreign dye substance. Values will be low in cases of cardiac decompensation and they may be high in nephritis, especially acute nephritis, though sometimes also in the chronic form of the disease.

The result depends very much on the efficiency of the blood circulation and on water excretion of the kidney. In the presence of marked jaundice, special technic is required for the reading of the test.

Some people have modified the original phenolsulphonphthalein test and measure the appearance time of the dye in separately catheterized kidneys. This modification depends on blood circulation primarily and sometimes is a more sensitive test of kidney function than the former.

4

Blood Urea Nitrogen and Non-protein Nitrogen:—The normal B.U.N. is 7-15 mg. per 100 c.c. and the normal N.P.N. 20-35 mg. per 100 c.c. of blood. The finding of a normal value for either of these constituents shows that the kidney is effectively able to excrete solids. Used as a test of kidney function, this also depends on blood pressure, nitrogen ingestion, nitrogen catabolism and the state of hydration of the patient's tissues.

5

Urea Ratio: — Mosenthal and Bruger[3] have made use of the urea ratio to estimate kidney function. This factor is $\frac{100 \times \text{B.U.N.}}{\text{N.P.N.}}$

They claim that it is a more sensitive test than ordinary B.U.N. or N.P.N. determinations.

6

Clearance Tests:—These have been generally found to be the most sensitive tests of kidney function since they measure the ability of the kidney to excrete some definite substance, usually one physiologically present. Van Slyke and coworkers,[4] of the Rockefeller Institute, showed that when the normal human kidney excretes more than a certain volume of urine the amount of urea excreted varies directly as the urine volume and represents a constant proportion of the urea present in the blood. This certain amount of urine was called the "augmentation limit" and in humans varied between 1.7 and 2.5 c.c. per minute. When less than this amount of urine was excreted per minute they showed that the urea present in the urine varied inversely as the volume of urine, so that the same patient by excreting one-quarter the volume of urine puts out one-half as much urea.

They have two figures:

$$\text{Cm (maximum clearance)} = \frac{UV}{B}$$

$$\text{Cs (standard clearance)} = \frac{UV\sqrt{V}}{B}$$

Here, U is urine urea, B is blood urea and V is the volume of urine formed per minute. The values Cm for urine formation rates greater than 2 c.c. per minute, and Cs for urine formation rates less than 2 c.c. per minute, represent a theoretical figure for the amount of blood which could be cleared of all its urea nitrogen in one minute.

The normal Cm averages 75 c.c. per minute with a variation from 40-85 c.c. per minute and the normal Cs averages 54 c.c. per minute with a normal variation from 30-65 c.c. per minute.

Other clearance tests have been used in which the kidney ability is measured to excrete various substances such as creatinine, inulin, xylose and sodium ferricyanide. The creatinine clearance in particular is a very good measure of the glomerular activity in the kidney since this substance is not reabsorbed or secreted in the tubule.

Evaluation of Kidney Function Tests

We have not used all of the above tests sufficiently in this hospital to estimate their value, and for those which are used, I have not had the time to consider a lengthy series of cases and report to you on the results, so I shall have to give you the opinions of a few workers who have done what I have not.

For routine use, Platt[5] employs only blood N.P.N. and a concentration test. He advises that the Volhard concentration test (similar to the Mosenthal) is a very sensitive measure of early kidney insufficiency and that N.P.N. values tell how far this damage to kidney function has progressed. Edematous nephritis, according to him, is due to decreased glomerular filtration. The urine is usually concentrated well and there is no nitrogen retention. Uremic nephritis, on the other hand, is due to increased glomerular filtration and lack of reabsorption in the tubules. There is fixation of specific gravity and N retention.

Gradwohl and Scherck[6] have reported on the use of the B.U.N. and P.S.P. tests in urological conditions. They found that when they disregarded a low P.S.P. test in the presence of a normal B.U.N. their operative risks recovered uneventfully. The P.S.P. was sometimes normal when the B.U.N. was raised and these cases did not do well postoperatively. In general, they consider a P.S.P. test occupies a subordinate position. If it is low it is much more significant than when it is normal.

Frothingham, Fitz, Folin and Denis[7] used P.S.P. and N.P.N. as measures of kidney function after experimental uranium nitrate nephritis in rabbits. They found that the P.S.P. test measures only the action of the kidney for the moment, while the B.U.N. or N.P.N. is a better estimate of the kidney's ability to function.

Freyberg[8] recently has compared urea clearance, 15 min. P.S.P. excretion and the Lashmet-Newburgh concentration tests. He advises that the last of these three is the most sensitive test for kidney function except in the presence of loosely held edema. He objects to the urea clearance on grounds which I do not believe have much weight, since he claims to have obtained low values with less than 20 c.c. per hour secretion of urine, and suggests there is much chance of technical error in the performance of the clearance test. He states that B.U.N. figures measure only the ability of the kidney to excrete solids.

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Van Slyke and coworkers[9] have done probably the most extensive work with the urea clearance test. They have compared it with the other tests on large series of cases. They find it a more sensitive test of kidney function than the P.S.P. excretion or the B.U.N. values, and serial studies on various cases show that changes in P.S.P. and B.U.N. occur later than changes in urea clearance with inception of kidney disease, and that return to normal is more rapid for P.S.P. and B.U.N. than for urea clearance during recovery.

From this small review of a few reports it becomes evident that many factors must be considered in the evaluation of kidney function tests.

As early as 1904 Widal and Javal[10] noted that B.U.N. could be normal in the presence of marked kidney insufficiency provided the patient was on low nitrogen intake, yet *this point is often overlooked in hospitals today.* In the evaluation of B.U.N. values only, it is very important that the various factors which have to do with the level of the B.U.N. be considered. These factors are protein intake, liver disease, state of hydration in the tissues, and last but not least, blood pressure. Thus, a B.U.N. of greater than 15 does not necessarily mean insufficiency, since the same picture may be given in the presence of extra-renal factors such as increased tissue break-down as occurs in fevers, or decreased blood pressure as in cardiac decompensation, and a B.U.N. of less than 15 does not rule out kidney insufficiency, because it may be due to decreased protein intake, diuresis, or decreased urea formation.

My own feeling is that the urea clearance is the most sensitive test and the one which corresponds best to the physiological mechanism, but that it should only be used in cases where B.U.N. is normal and other tests give questionable evidence for or against suspected kidney disease. A urea clearance of less than 50% should always be taken as definite evidence for kidney insufficiency.

For routine use some form of concentration test *and* the determination of B.U.N. usually give the information which the surgeon requires in evaluating his risks. An explanation should always be sought for fixation of the specific gravity of the urine at low figures and an explanation is also necessary for every B.U.N. which exceeds the normal upper limit of 15 mg. per 100 c.c. of blood.

Physiology of Liver

Besides the numerous functions, which by experimental work have been ascribed definitely to the

liver, this organ seems to be the scape-goat of medical science, and all physiological processes which cannot be proven to occur in other organs are attributed to the liver. Some of the functions of the liver are as follows:

1

Excretion: — Excretion of pigments derived from blood, cholesterol and dye stuffs.

2

Secretion:—Bile salts for digestion (emulsifying action on fats).

3

Metabolism:—Desaturation of fats, formation of phospholipids, storage of glucose, deaminization of amino acids, urea formation, serum protein synthesis, conversion of fat and protein to glucose, formation of bile pigments from old hemoglobin, formation of enzymes which act in intermediate metabolism such as arginase, guanase, etc., detoxication of drugs and poisons.

As numerous as the functions which the liver performs are the tests which have been utilized by various workers as measures of hepatic function.

Tests of Liver Function

1

Icteric Index and Quantitative Van den Bergh:—Normal limits for the icteric index are 2 to 6. For latent jaundice values are 6 to 16, and above 16 clinical jaundice is almost always present. The icteric index is a measure of the yellow color of the serum, and in the absence of yellow pigments such as carotin, this is all due to bilirubin. Sometimes there is a slight discrepancy between the icteric index and quantitative Van den Bergh (specific for bilirubin) because part of the bilirubin exists in a colloidal (?) form which does not color the serum, but in general the quantitative Van den Bergh in mgms. per 100 c.c. of serum is about 1/10 of the icteric index value. After 48 hours on diet free from carrots and beets, any pseudoicterus due to carotin is absent. This test measures only retention of one of the excretory products of the liver and tells nothing about the process.

Qualitative Van den Bergh: — This test attempts to distinguish the source of increased bilirubin in blood serum. The immediate direct reaction is indicative of obstructive jaundice while the delayed reaction is indicative of hemolytic jaundice. However, in actual practice, where the icteric index is high the qualitative Van den Bergh always gives an immediate direct reaction, and biphasic reactions are usual with slightly increased bilirubin. The biphasic reaction indicates a combination of hemolysis and obstructive jaundice and would be of little value.

3

Cholesterol:—Serum cholesterol values, when not affected by metabolic processes such as hypertension, thyroid dysfunction or fever, are a measure of liver function. Thus, values below the normal of 140-220 mg. per 100 c.c. are found in extensive parenchymatous disease of the liver. In obstructive jaundice, cholesterol values are raised by a long standing obstruction, but they may be normal in early cases or in incomplete obstruction.

4

Serum Protein:—Since the liver is the site of formation of serum proteins, an estimation of these reflects one phase of liver activity. In the presence of liver damage serum proteins are below the normal of 6-8 gm. per 100 c.c. This is the explanation for peripheral edema that is often associated with liver damage.

5

Urobilinogen in Urine:—This is high in increased blood destruction by the liver and low in obstructive jaundice. It is formed from the bilirubin absorbed through the intestinal wall and thus would be low in cases with clay colored stool where the bile is not excreted normally.

6

Various Non-specific Tests:—Two of these which have been proven to be of no value in this hospital and to depend only on changes of chemical constituents which are not pathognomonic of liver disease are the Takata-Ara[11] test on blood serum and the Rosa[12] reaction on urine.

7

Duodenal Drainage:—Careful collection and examination of the various bile fractions by means of duodenal intubation can be of value in the estimation of liver disease. The presence of pigment and cholesterol crystals are of some value in diagnosing presence of stones in the gall bladder.

8

Galactose Tolerance: — For this test the patient is fed 40 grams of galactose and given 200 c.c. of water to drink. Since the liver ordinarily converts galactose to glucose and since galactose is an abnormal sugar it would be excreted by the kid-

neys. The excretion of galactose during a period of five hours after ingestion is a measure of liver function. The normal excretion is not more than 3 grams of galactose. It is important that urine collection be accurate and that the urine be preserved to prevent bacterial decomposition if the determination is not carried out at once.

9

Dye Excretion:—After the injection of standard amounts of Bromsulphonthalein or Tetrachlorphthalein the liver removes these from circulation within a certain limit of time. Thus, normally not more than 5% of the standard dose of Bromsulphonthalein remains one-half hour after injection and none remains one hour after injection.

10

Hippuric Acid Excretion:—When benzoic acid is fed, the liver conjugates this with the amino acid glycine to form hippuric acid which is excreted by the kidney. Hippuric acid is a normal constituent of urine after eating cranberries, which contain benzoic acid. For this test 6 grams of benzoic acid and 200 c.c. of water are given to the patient and the urine excreted during the next four hours is collected for determination of hippuric acid. Normal individuals excrete 3 grams of the benzoic acid as hippuric acid. In parenchymatous disease of the liver, less than 3 grams is excreted. Excretion varies according to surface area so that the normal variation is from 85-115% of 3 grams.

Evaluation of Liver Function Tests

Greene, Bercovitz and Hanssen[13] in 1935 reviewed recent developments in liver physiology and liver tests. They found that the galactose test was the best of the carbohydrate tests, though it must be evaluated along with other determinations. They found cholesterol raised in obstructive jaundice and low in marked liver damage. Total protein of serum was usually low and the A/G ratio sometimes lowered in marked liver damage. They also refer to various workers who have shown that phosphatase is high in cirrhosis of the liver, obstructive jaundice and hepatitis, but normal in hemolytic jaundice.

Magath,[14] in a series of cases, found that the Takata-Ara reaction was of little value and that the Van den Bergh was a slightly better test.

Snell and Plunkett[15] reported a series of cases comparing dye excretion, hippuric acid and galactose tolerance.

They found that the hippuric acid test, as suggested by Quick,[16] correlated well with the condition of livers examined at operation and at autopsy. They found it especially useful in jaundice where dye excretion cannot be used and in non-jaundice cases where galactose tolerance is of little value.

Quick[16] has extensively investigated the hippuric acid test which he advocated as a liver function test and considers that cases with less than 50% excretion are very poor operative risks.

Bensley[17] concludes that the galactose tolerance test is significant only when excretion is greater than 4 grams.

It is interesting that Hunt,[18] in a study of bile drainage, found pigment and cholesterol crystals in 20% of presumably normal cases and in 77% of proven cholelithiasis cases.

To properly evaluate liver function, one must be able to consider the results of several of the known tests since no liver test is entirely satisfactory. The hippuric acid test seems to be the most satisfactory one devised as yet and the little experience we have had with it in this hospital seems to indicate that it will be of definite value, while we must consider the galactose tolerance test of lesser importance since all of the tests run on various types of cases in this hospital have shown nothing definitely abnormal. Bromsulphonphthalein excretion, with which I have had no experience, seems somewhat like the P.S.P. excretion test of kidney function since it is a dyestuff foreign to the human body. Deep jaundice interferes with the reading of the test.

Conclusion

Some of the more important kidney and liver function tests are considered and submitted with suggestions for your evaluation in the clinic.

For kidney function a concentration test and B.U.N. determination will evaluate operative risks. P.S.P. excretion sometimes adds to the story but is of lesser value. Urea clearance tests, which are very sensitive tests of kidney function, should only be used when other tests do not prove a suspected insufficiency.

No liver function test is entirely satisfactory but a good estimate of the condition of the liver can be gained from consideration of icteric index, urobilinogen in urine, serum cholesterol and protein values and a hippuric acid excretion test. Repeated studies are better than single observations.

Interpretation of kidney and of liver function tests should always depend on careful weighing of all factors involved.

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General Laws of R. I. 1923
CHAP. 365. SEC. 33

If the estate of a decedent is insufficient to pay his debts, the same, after deducting the charges of administration and such property as is set off and allowed to the widow and family, shall be applied to the payment of his debts and charges in the following order:

First. The necessary funeral charges of the deceased.

Second. The necessary expenses of his last sickness.

Third. Debts due to the United States.

Fourth. Debts due to this state, and all state and town taxes.

Fifth. Wages of labor performed within six months next prior to the death of such deceased person, not exceeding one hundred dollars to any one person.

Sixth. Other debts filed within six months of said first notice.

Seventh. All other debts.

If there is not sufficient property to pay all the debts of any class, the creditors of that class shall be paid ratably upon their respective claims; *and no payment shall be made to creditors of any class until all of those of the preceding class or classes have been paid in full.*

WHY PEOPLE MISBEHAVE

Hugh E. Kiene, M.D.
Director of Psychiatric Department, Charles V. Chapin Hospital, and
Philip Solomon, M.D.
The Emma Pendleton Bradley Home, East Providence, R. I.

Why do people misbehave? Those of you who are fathers and mothers doubtless have a particular interest in this problem, for children who never misbehave are not common. We live in a complex modern world, and it is a rare child indeed who does not often bump up against our adult ideas of law and order. But before speaking of misbehavior let us consider for a moment behavior in general.

The problem of behavior is as old as mankind. For untold centuries, its study and control lay primarily in the hands of the church. Social conventions, of course, existed but it was the high priest who dictated the ultimate right and wrong. In later years, the state began to take over much of the supervision of human behavior. The law, with policemen to enforce it, became the chief instrument of controlling individual conduct. But the last hundred years has seen a remarkable change in our civilization. One factor, previously almost unknown and insignificant, has grown steadily until it now occupies a leading position in all human relations. I refer to the progress of science. Science today is playing an increasingly important role in every human institution. Its contributions to the happiness of mankind are already beyond measure. What, then, has the scientist to say about human behavior?

Scientists have been interested in human behavior from a number of points of view. It has been an object of major attention in sociology, anthropology, criminology, psychology and about every other "ology" you can think of. But this afternoon, we are speaking to you from the point of view of the physician. You may ask, "What has the physician to do with behavior? His job is just to get us well when we are sick." The answer is this: Certainly the physician is interested in your physical health, but he is concerned with more than that. He is interested in your mental and emotional health as well. The goal of the modern doctor is not only a

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A Sunday afternoon address, delivered at the Medical Library, November 15, 1936, under the auspices of the Committee on Education of the Rhode Island Medical Society.

healthy patient but a *happy* one. It is just here that misbehavior comes into the picture, because the individual who misbehaves is by and large destined to be a very unhappy person.

The branch of medicine that is particularly interested in such unhappy individuals is called psychiatry. You may have thought that the psychiatrist dealt only with cases of insanity. Let me assure you that by far the greater part of the average psychiatrist's practice is made up of persons in whom there is no suspicion of insanity, but whose lives have become miserable because of some subconscious conflict or other emotional disturbance. In these cases, and especially in cases where misbehavior has become a habit, the physician who specializes in psychiatry utilizes the modern equipment of science and is often able to discover the cause or causes, the correction of which contributes enormously to the happiness of the patient.

Dr. Kiene and I are going to describe for you authentic cases from our own experience in whom misbehavior has been the major issue. I shall tell you about children. Each of them has been studied at the Emma Pendleton Bradley Home in East Providence. As you may know the Bradley Home is a new institution, which does not have its counterpart anywhere in the world. Its sole purpose is the study and treatment of children who have normal intelligence but are the victims of nervous, emotional or mental conditions that render them a problem to themselves, their families or the community. Here, children who come from all over the Eastern States, are placed in an environment which is as nearly perfect as any you could imagine. It attempts to combine all the best features of the modern school, hospital, and home. But you will better understand what this means by hearing how it functions in actual cases.

The following cases were given in detail in the radio address, but have been condensed to conserve space in publication.

Jimmie, twelve, was referred to the Bradley Home because of frequent episodes of stealing, and extreme backwardness in school. On examination it was found that his vision was unusually poor. When glasses were prescribed, the boy learned rapidly, and no longer had to compensate for his marked inferiority in school by feats of bravery in the form of thieving.

Cases like Jimmie's are not uncommon. Children with marked physical handicaps suffer exceedingly from feelings of inferiority. Failing to keep up with their mates inside the bounds of acceptable behavior, they are spurred on to daring deeds which serve to bring them some share of satisfaction and recognition. It is unfortunate that this type of case may go for years without having its true nature recognized. Early medical attention in such a case can prevent unacceptable habits of behavior that later in life might be difficult or impossible to remedy.

Billy, ten, was a normal boy to the age of eight, when, without apparent reason, he began to misbehave badly in school and at home. On investigation it turned out that Billy was unhappy because of a sordid home situation, involving a recently acquired selfish stepmother, her bad-tempered father, and convict brother. At the Bradley Home, Billy became very proficient in sports, and began to catch up in his school work. It took eight months of personal interviews, however, before he finally blurted out his hatred for his stepmother. His improvement was then rapid and he was soon discharged to a foster home.

Tommy, eleven, had been destructive, disobedient, hyperactive, impulsive, and stubborn all his life. Some days, however, he would be perfectly good, and on other days terrible. There seemed to be no reason for these cycles. When delinquencies occurred, the family physician sent him to the Bradley Home.

Tommy was found to be large for his age, well muscled, and in good apparent physical health. An investigation of the family by the social worker revealed some interesting information. Five near relatives on the father's side had had convulsions in infancy, and were said to have been behavior problems similar to Tommy later in life. Three of Tommy's sisters and brothers had had convulsions in infancy. Tommy himself had had convulsions two or three times a month from the ages of eight months to three years. Since then he had had a number of nightmares in which he would scream aloud and afterwards seem confused, but he had no other attacks of any kind. The significance of this data will become clear a little later.

At first we had quite a time with Tommy. He was very rude and used profanity toward the attendants, "sassed" the nurses and was impolite to the doctors. He leered, scowled, defied all authority and tried to bully the smaller children. He felt inferior in group activities since he did not know any of the games,



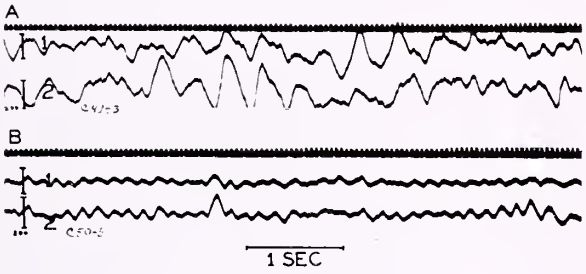
The Emma Pendleton Bradley Home

and compensated by making many boastful threats. He was antagonistic toward any suggestions, and in the personal interviews with the physician boasted that no one could get anything out of him.

On the ward he was very hard to handle. Once he refused to go to the dental clinic, and tore his shirt. When he found that he still had to go he cried, shouted, and swore violently, but went. Another time he ran away from the hospital. When he was returned he was quite obviously surprised and disappointed that no fuss was made over him and that he was not even punished. Some weeks later he ran away again. This time he persuaded an intellectually inferior child to go with him. The two then went to Tommy's home and attended a show with tickets given them by Tommy's brother. They returned to the hospital about midnight. The next morning the situation was discussed with Tommy and the seriousness of involving the other child was pointed out to him. It was explained that for this reason and because of the considerable inconvenience he had caused the staff, he would have to be severely disciplined. But Tommy took discipline very well.

After a few months there was a noticeable improvement in Tommy's behavior. He made a good contact with one of the psychiatric workers and began to confide in her. His boasting diminished and he showed good insight into his personality difficulties. The one thing that did not change was the peculiar fluctuation in his behavior from day to day. In school about two days out of every week he was so confused that trying to teach him anything at these times was profitless.

About this time, a new instrument was built at the Bradley Home by Dr. Herbert H. Jasper and Dr. Howard L. Andrews of Brown University. This is the electro-encephalograph, which records the electrical activity of the brain, in much the same manner that the electro-cardiograph records the electrical activity of the heart. This instrument became important inasmuch as during epileptic attacks very marked changes occur in the brain waves. Moreover, it was found that the abnormal waves, called "seizure waves," often appeared *between* attacks in epileptic individuals. We therefore had a way of diagnosing epilepsy without the necessity for observing attacks. Now, the strange and exciting discovery that this instrument permitted us to make was this: When we took brain wave records on Tommy who was not suspected of having epilepsy, we found the same "seizure waves" that epileptics have. What is more, on the days when Tommy did poorly in school and seemed especially bad-tempered, his brain record was full of "seizure waves," while on good days when he was well behaved, his brain record was perfectly normal! Here, then, was the explanation for Tommy's peculiar behavior. We had come upon a new and unsuspected cause for misbehavior. It had previously been recognized that some epileptic individuals behave badly after their attacks. In fact, many crimes, even murders, have been committed under these circumstances. But that a child who was not regarded as an epileptic could have the same brain disturbances and the same type of behavior was something not considered before. Later, I shall show you lantern slides of Tommy's brain waves (see figure), but now we will leave the behavior problems of children and proceed to the discussion of misbehavior in adults. Dr. Kiene will describe some interesting cases for you.



Legend for Figure

Tommy's brain waves: A. On a "bad" day (see text). B. On a good day. Lead 1 in both records was taken from an indifferent ear electrode to the vertex of the head; lead 2 simultaneously from the same indifferent to an occipital electrode. For technique, see *Jasper, H. H. and Andrews, H. L., Jour. Gen. Psychol.*, 1936, 14:98-126.

The time line at the top of each record represents 1/20 seconds. The calibration lines under the letters "A" and "B" represent the excursion produced by a signal of 200 microvolts.

Record B shows normal "alpha" waves; record A shows large 3 a second "seizure" waves.

Similar problems to those mentioned by Dr. Solomon are also found in adults. Much understanding of adult misbehavior can be obtained by comparing it to the usual behavior of a child. "He doesn't act his years," as often heard, has basis in fact. The process of "growing up" is an important one and the unusual symptoms mentioned in con-

nection with the problems of the following people are evidence of a failure in "growing up." "Growing up" is retarded by such happenings as sickness, abuse which can be both physical and mental, and overprotection by not allowing the child to acquire knowledge pertaining to life which he must know when he is "grown up."

Treatment of the person who has failed to "grow up" can be handled satisfactorily by the physician if the problem is presented to him early enough.

The four people whose stories I am now to present indicate the importance of early medical treatment.

Alice is a young woman who was brought to the hospital because she was wayward, delinquent, and had threatened suicide. This misbehavior began early in life and was, to a great extent, due to a hip injury which she suffered as a youngster. Alice was neglected in early life in that the hip injury which she sustained was not given medical attention. She developed an inferiority feeling because of her resulting limp. Her attempts to compensate by lying about others brought her only trouble and unpopularity. Her mother sympathized and overprotected her, which made matters worse. As she grew older she was a problem wherever she went. Once she untruthfully accused a man of assaulting her. She quit one job after another, always going to her mother for sympathy.

As she became unpopular with respectable people, due to the embarrassment she caused them through her lying, she began to associate with men and women of low moral character, leading to the birth of several fatherless children. She contracted a social disease requiring hospital care for a time.

The police became interested when her employer reported Alice to them for charging merchandise to the employer's account. Her family paid for the merchandise but when the same offense was repeated time and time again, Alice was taken to a physician who realized her misbehavior was due to mental illness and arranged for proper treatment.

Prevention of this misbehavior could have been accomplished by proper medical treatment of the hip injury at the time of its occurrence.

Albert was apprehended by the police because of improper advances to a woman on the street. He had been a perfectly normal, happy husband and father until 1918 when he contracted sleeping sickness during the influenza epidemic. His personality changed, and he became irritable and unable to work. His wife, not understanding what was going on, left him. Albert was regarded as a bad man instead of a sick one. Proper medical handling restored Albert to a more tolerant, understanding home, and misbehavior was not repeated.

Joe, as a boy, developed bad teeth because of the lack of dental attention. As he grew older, the infected teeth caused him to have severe headaches. Soon Joe began using a certain drug which was advertised as a panacea for all headaches regardless of cause. As time went on, he was forced to use more and more of the drug, until finally he was using enormous doses. Joe felt that he "just couldn't get along without it." It was not long before there were obvious changes taking place in Joe's personality. Because of his irritability his wife left him. Gradually his physical and mental health failed. He had to stop work and stay in bed most of the day. He became confused, hazy, and forgetful. At times he thought he heard voices, and he imagined all sorts of strange things. When a doctor was called, blood and spinal fluid tests were taken and it was found that Joe was being poisoned by the medicine he had been buying by himself in the drug store. Proper treatment was started immediately and eventually Joe recovered. It was only after all this, instead of long before, that Joe had his teeth looked after.

Jane was described as a lazy, worthless young woman. She complained of eye trouble, had vomiting spells, slept poorly, and was easily fatigued. When the situation was investigated by a physician it was found that Jane was not really bad, but was the victim of circumstances. She was being hounded by a vicious former employer, and her anxiety was at the root of all her symptoms and misbehavior. With the help of a social worker, the physician was able to straighten things out, and Jane became a healthy, hard-working, independent young woman.

In conclusion, we wish to emphasize the main points covered. Misbehavior in both children and adults does not just merely happen, but is due to definite causes. These are numerous and include physical defects, poor environment, various diseases, improper and unsupervised use of medicines, and many other causes that can be evaluated by the physician. Our job as physicians is to discover these causes and correct them; your job as intelligent laymen is to refer these problems to us for help before they become too serious.

THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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CHILD HEALTH SERVICE UNDER THE SOCIAL SECURITY ACT

The Social Security Act, under Title V, provides in part as follows: "For the purpose of enabling each state to extend and improve—services for promoting the health of mothers and children—there is hereby authorized to be appropriated for each fiscal year—$3,800,000." This money is to be distributed among the states if their plans are approved by the Chief of the Children's Bureau. The states are allowed great freedom in formulating their plans, the main restrictions being that the plans must provide for financial participation by the state, administration by the state health agency, such methods of administration as are necessary for efficient operation, such reports as the Secretary of Labor may require, the extension and improvement of local maternal and child health services, co-operation with medical, nursing and welfare groups, and demonstration services in needy areas.

There is no need at this time to discuss the social significance of the whole act. This particular part supplies an annual sum of about $34,000 for the improvement of maternal and child health service in Rhode Island. There is no reason to doubt that it is possible to spend this comparatively small sum usefully in increasing educational and public health activities, without encroaching on the field of private practice or developing state medicine. It is also probable that other groups will bring pressure to bear to have activities financed that we do not consider proper or useful.

The act requires co-operation with medical groups. It would seem that the interest and the duty of the medical profession would best be served by the appointment of a Child Health Relations Committee of the Rhode Island Medical Society to enter into these plans. Such a committee, if active and wise, would have a double function. It could advise the State Health Department in the development and administration of the work, and its approval of the plans would be of considerable help in gaining the co-operation of the physicians in the areas where the work is being done.

We definitely urge the appointment of such a committee. It would be well if the committee were largely composed of pediatricians, as the discussions of the administration of child health services under the Social Security Act are chiefly at the meetings of the Academy of Pediatrics and in the pediatric literature. Dr. McLaughlin and Dr. Gleason would welcome such action by the State Society, as it would strengthen their hands and make their task easier and more effective.

SYPHILIS AND THE STATE

Some thirty years ago the populace of this country were taken aback by propaganda for the control of a disease that was only mentioned in whispers—tuberculosis. The resistance of the press being overcome, education on prevention commenced. The success of this campaign is today accepted almost as matter of fact. We are now living in the early days of another campaign—a battle against another disease whose name was forbidden in every newspaper of this country till within the last year. The breaking down of this ridiculous attitude on the part of the radio and the press is largely due to the untiring efforts of Dr. Thomas Parran, Jr., our new surgeon general. Unlike tuberculosis, medical science has a specific treatment for syphilis, a treatment which actually is cheaper for the patient to purchase than that for tuberculosis.

Dr. Parran has in mind principles of attack that are well founded and will undoubtedly prove efficacious. However, there are certain aspects of the problem that should be debated promptly. The medical profession is hearing much about socialization of medicine, and most of the attack is coming from the lay press. We are not surprised to learn that there is an element within the profession in favor of socialization, but we are shocked to realize that they are depending on this program to further their cause. At a recent Regional Conference on Social Hygiene in New York, to which, incidentally, Dr. Parran gave an address, it was urged that free venereal clinics be established as an integral part of

this plan. Of course, the word "free" is not really the correct word. Better would it be to say—a clinic supported by the taxpayer. From the patient's standpoint every one agrees that he receives the best treatment at the hands of his personal physician. The dreary monotonous impersonal routine of a clinic is all too well known to every physician, and we know how dissatisfied many patients are. And we know from the standpoint of public health that the private physician can treat just as efficiently as the clinic, too. This has been demonstrated in the past where the physicians have been educated. But there is still another angle. The physician is still a taxpayer in America. If statistics are correct that 10% of the population have venereal disease, and this 10% are to be treated largely by free clinics—that is, clinics maintained by the taxpayer—then the physician will indeed find himself assaulted from two sides. For his income will be reduced by removing a portion of his practice, and his taxes will be raised to support this program. It seems much more reasonable to approach this problem somewhat as the Wayne County Medical Society did that of diphtheria control a few years ago. The drugs could be supplied at minimum cost by the State. In the case of the indigent patient, a small remuneration could be given the physician for his time. Although definite information is not at hand, it almost seems self-evident that this procedure would be cheaper in the long run to the tax-payer, and much more satisfactory to all concerned. In the meantime, action is needed, and needed quickly if the physician's present status is to be maintained. The Rhode Island Medical Society should be among the first to express itself on this subject.

RADIO ADVERTISING

The radio announcer who solicitously urges us to hurry out to the corner drug store and get a bottle of Pipp's Panacea for Piles and Pimples is not really interested in the state of our health; he just needs the money. Radio exploitation of the credulous succeeds because this evident fact is not appreciated.

A mother of four children whose husband earns $15.00 a week, notes that she spends $1.00 a week—$52.00 a year—on a radio advertised "antiseptic." Each child gargles every day in the hope to ward off colds. This multiplied by thousands of cases gives one an idea of the millions wasted every year on worthless "antiseptics" that were never known to kill a germ.

We hear about antiseptics galore, vitamin cough drops, all sorts of "pure" bread—anything you wish. And the public believes what it hears over the radio. So far there is no known prevention for colds but if we believe what we hear we can go to the druggist and stock up on "anti-cold" preparations.

While we are on the subject of antiseptics, Robert Nye has recently shown in *The Journal A. M. A.* (108, 280, Jan. 22, 1937) that tincture of iodine, 1 part in 50 parts of water, is more efficacious than most other preparations, and much less expensive.

Someone once said that the law prohibiting spitting on the sidewalks in Rhode Island presented little difficulty because with a little practice one could spit over into Massachusetts. Along this line the radio medical "specialist" who was prohibited from broadcasting his stuff over American radios, now pours it out from a powerful Mexican station.

The public should be protected against fake medical preparations. The physician can help by keeping the A.M.A. "Nostrums and Quackery" on his waiting room table. There should be some law to prohibit medical preparations or treatments from being advertised in any publication or on the radio unless they are approved by medical science. A modern democracy demands this sort of protection for those who need it. It might be well to write to our senators and representatives in the hope that something may be done.

FOR WHOSE BENEFIT?

Every proposal for change in medicine should be tested with the question: "For whose benefit?" Unless the change will help, either directly or indirectly, in the fight against disease and death, it cannot be justified. The fact that it may increase the income of physicians, help pay the interest on hospital investment, or provide salaries for a body of administrators, unless it will also improve medical service, is no justification. This is a simple test, but applied strictly to many of the proposals for medical changes before the public at the present time it would elicit a verdict of condemnation.

—*Jour. A. M. A.*, Feb. 20, 1937.

PAWTUCKET MEDICAL ASSOCIATION

Minutes of the Annual Meeting

At the Annual Meeting of the Pawtucket Medical Association on March 18, 1937, a banquet was held at the Slater Hotel in Pawtucket, R. I. Fifty-four members and guests attended. Two new members were elected: Dr. Francis L. Burns, associate, and Dr. Natalie Kechijian, a regular member. The application of Dr. Omar Massie was presented. Dr. Charles L. Farrell, as toastmaster, introduced Mr. John Halloran, Manager of the American Telephone and Telegraph Company, guest speaker. The address was supplemented with sound movies. Dr. Roland Hammond represented the State Society. The following officers were elected:

President—E. A. Cormier.

Vice President—Charles L. Farrell.

Secretary—Thad. A. Krolicki.

Treasurer—Earl J. Mara.

Standing Committee—E. M. Clarke, J. Lincoln Turner, Henry F. Hanley, Earl F. Kelly, Walter J. Dufresne.

Ethics Committee—James L. Wheaton, Charles H. Holt, John F. Kenney, Earl F. Kelly.

Library Committee—George J. Howe, Earl J. Mathewson, J. Brewer Marshall.

Delegates—Stanley Sprague, G. Raymond Fox, Robert T. Henry, Earl F. Kelly.

Councillor for 2 years—Charles H. Holt.

Respectfully submitted,

THAD. A. KROLICKI, M.D.,
Secretary.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the March Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Peter Pineo Chase, Monday, March 1, 1937, at 8:30 P. M. The minutes of the last meeting were read and approved.

The Secretary read two communications from the Rhode Island Medical Society. The first of these announced a change in the by-laws whereby termination of membership in a district society would automatically result in termination of membership in the State Society. The second communication concerned a proposal to increase membership in the State Society. This was referred to the Standing Committee for consideration.

Their applications having been approved by the Standing Committee, the following were elected to membership: William John Schwab, Louis Davis Lippitt, Marion A. Gleason, Ernest Allen Burrows.

The Secretary read an obituary on the late John G. O'Meara, prepared by Drs. Richard F. McCoart and Charles A. Gannon. It was voted to spread this on the records and to send a copy to the family.

The President reported the death of Dr. Charles F. Deacon, Treasurer of the Association for the past nineteen years, and appointed Drs. George S. Mathews and D. Frank Gray as an Obituary Committee.

The first paper of the evening was given by Dr. Alex. P. Aitken of Boston and was entitled, "Conservatism in the Treatment of Fractures in the Young." Dr. Aitken stated that about 95% of fractures at the epiphyseal line involve a shearing off of the epiphysis without injury to it. In such instances malposition of the epiphysis tends to correct itself to a remarkable degree. If, on the other hand, the cartilage plate is broken, deformity results inevitably. The paper was discussed by Drs. Danforth, Hammond and Horan.

The second paper of the evening was given by Dr. Torr Wagner Harmer of Boston and was entitled, "Injuries to the Hand." Dr. Harmer limited himself to a discussion of injuries to tendons and nerves. He reviewed the anatomy of the region and stressed the value of careful pre-operative examination, meticulous repair, and early use of the hand following operation. The paper was discussed by Drs. Cameron and Danforth.

The meeting adjourned at 10:35 P. M. Attendance 96. Collation was served.

Respectfully submitted,

FRANK B. CUTTS,
Secretary pro tem.

WASHINGTON COUNTY MEDICAL SOCIETY

At the annual meeting of the Washington County Medical Society, held January 13, 1937, the following officers were elected for the ensuing year:

President—Dr. Walter J. Grenolds, 9 Elm Street, Westerly.

First Vice-President—Dr. Louis C. Cerrito, 1 Pleasant Street, Westerly.

Second Vice-President—Dr. William F. Thompson, Washington Trust Bldg., Westerly.

Secretary and Treasurer—Dr. John Champlin, Jr., 3 Granite Street, Westerly.

Auditor—Dr. Samuel C. Webster, 99 High Street, Westerly.

Censor—Dr. John Paul Jones, Wakefield, R. I.

Dr. William P. Buffum of Providence then addressed the Society on the subject "Allergy." There was a full attendance at the meeting, which was held at 11 A. M. at the Westerly Hospital. Collation was served.

Respectfully submitted,

JOHN CHAMPLIN, JR., M.D.,
Secretary.

WOONSOCKET DISTRICT MEDICAL SOCIETY

At the Annual Meeting of the Woonsocket District Medical Society the following officers were elected:

President—James M. McCarthy.
Vice-President—Francis J. King.
Treasurer—Victor H. Monti.
Secretary—G. G. Dupre.
Delegate—H. E. Gauthier.
Counselor—W. C. Rocheleau.
Censors—Auray Fontaine, H. Lorenzo Emidy.

The Society holds meetings every other month, beginning in October.

LOCAL EVENTS

February 23. The regular monthly meeting of the Malpighi Medical Club was addressed by Dr. F. A. Simeoni, on the subject "Reynaud's Disease and Desensitization of the Neuro-effector System." Dr. Simeoni is Research Fellow at the Department of Physiology of Harvard Medical School. At the January meeting, Dr. Rocco Abbate spoke on "Protein Insulin in Diabetes."

February 24. The regular monthly meeting of the Jacobi Medical Club was held at the Miriam Hospital Annex at 8:45 P. M. Dr. Russel Bowman, Bio-chemist at the Rhode Island Hospital, gave a talk on "Laboratory Aids in Clinical Medicine."

March 7. The Sunday afternoon lecture at the Medical Library Building was attended by more than 375, an audience which not only filled all available seats but taxed the standing-room capacity of the auditorium. The speakers were introduced by Dr. Russell S. Bray, Chairman of the Committee on Education. The subject was "Cancer—Facts and Fancies." Dr. James A. McCann, the first speaker, immediately interested the audience with a statement of the increasing prevalence of cancer. He gave the origin of the words "tumor" and "cancer" and pointed out the difference between the two conditions. He outlined the precautions indicated by the precancerous stage and the treatment required for the cure of developed cancer. Surgical removal of the growth, radium and the X-Ray are the only efficient measures. Drugs, serum, and cancer pastes have done little good but a great deal of harm. Dr. McCann is impressed by the progress in cure of cancer during the past ten years as almost unbelievable. Dr. Herman C. Pitts was the second speaker. After reporting the great interest manifested at the recent meeting of the American Society for the Control of Cancer, he mentioned the success with which the great plagues of past ages have one by one been overcome and cited cancer as the plague remaining and increasing in prevalence. He described the fight against cancer waged in Rhode Island during the past ten years. Of the 3,000 cancer victims, a half must be treated in charitable clinics. He mentioned the Rhode Island Hospital, among hospitals of the State intended for the treatment of acute conditions, as never having refused admission to a cancer patient. Dr. Pitts finally appealed for support of the campaign against cancer which the Women's Field Army is opening. Following this lecture, the speakers replied to numerous questions from the audience.

March 12. Dr. Wilfred Pickles entertained the William W. Keen Medical Club. Dr. George W. Waterman read a paper on "Cervicitis—Symptomatology and Treatment." Dr. Waterman favors electro-coagulation, which may largely displace surgery in the treatment of cervicitis.

March 14. The second in the present series of popular Sunday afternoon lectures at the Rhode Island Medical Library was given by Drs. Charles S. Christie and Daniel V. Troppoli on the subject "Headache—Medical and Surgical Aspects." Dr. Christie outlined the common causes of headache, citing eye-strain, sinus infections, dietary indiscretions, and especially modern habits of living. He gave an emphatic warning against the unsupervised use of drugs for headache. Dr. Troppoli described

recent improvements in brain surgery which have greatly reduced its danger. The lectures were carefully prepared and were received with enthusiasm. Attendance 255.

March 15. At the meeting of the Thirty-four Medical Club, Dr. F. Ronchese read a paper on "Scleroderma." A review of the subject was presented, with special reference to etiology and treatment. Then a case was illustrated with wax models and photographs of keloidal scleroderma, or association of atrophy, scleroderma and keloid, which is a very unusual, perhaps unique, combination. Of surgical interest was the involvement of the breast by the process, with dimples, indurations and retractions suggestive of malignancy. A bilateral mastectomy was performed and the pathology was found to be scleroderma and keloid.

March 19. Dr. George L. Shattuck entertained the Friday Night Medical Club. Dr. Charles A. McDonald reviewed "The State Hospital after Two Years." As a sequel to the paper which Dr. McDonald presented two years ago, this subject was of special interest to the club. In his work as Director of various State hospitals, he has kept in mind the three factors: public interest, modern medicine and sound business. Considerable progress has been made in securing co-operation between the State institutions and the general hospitals and medical profession of the State. The work has been complicated by the extensive building program. In the discussion, the satisfaction with which the profession views the results of Dr. McDonald's two year service was constantly evident.

March 21. The third in the present series of popular Sunday afternoon lectures at the Medical Library Building was attended by an audience numbering more than 400. The speakers were introduced by Dr. George L. Young of the Committee on Education. Dr. Charles F. Gormly, the first speaker, chose as his subject, "How to Grow Old Gracefully." He explained that the great increase in population in Europe and America during the past hundred years was due not to an increased birth rate but to longevity increased by the conquest of disease. He cited present control of the diseases of infancy, of diphtheria, malaria, typhoid, tuberculosis, diabetes and pernicious anemia, and emphasized the importance of the new campaign against cancer. Dr. Gormly mentioned a high blood pressure with arteriosclerosis as the principal impediment to "growing old gracefully." As factors in attaining a graceful old age he recommended a balanced diet, out of door exercise, and especially, busy fingers and a hearty and contented mind. Dr. Henry A. Weyler, second speaker, defined "nostrums," recited the story of thallium acetate, and told of the dangers lurking in cosmetics, headache remedies, obesity cures, and in the unrestrained use of hypnotics. Dr. W. Henry Rivard, Dean of the Rhode Island College of Pharmacy, spoke briefly of the changes in pharmacy in recent years and of improvements in pharmaceutical education which have elevated pharmacy from a business to a profession.

March 24. At the regular monthly meeting of the Jacobi Medical Club, held at Miriam Hospital Annex, Dr. Chester Keefer of Harvard Medical School addressed the club on "Obscure Fevers and their Diagnosis."

March 30. The Malpighi Medical Club was addressed by Dr. Mario Castallo of Bland's Clinic at Jefferson Medical School.

Homeopathic Hospital of Rhode Island

The fourth lecture in the series arranged for the General Staff of the Homeopathic Hospital of Rhode Island was given at the hospital by Dr. W. Richard Ohler, Tuesday noon, March 16—"A Discussion of Certain Medical Problems."

Dr. Ohler emphasized the importance of typing and making blood cultures in all cases of pneumonia to determine the type and whether or not blood infection is present. Such examination gives a guide to dosage of serum and also prognosis in certain types.

Very significant statistics of pneumonia cases in the Boston City Hospital will be published in the near future.

The symptom of congestive heart failure has been found to be due to certain vitamin deficiency in cases of heart disease associated with beriberi.

Under diabetes was given the treatment of acidosis, dehydration and circulatory failure. Old insulin and protamine-insulin were compared, and the difference in shock from the two forms of insulin. The prominent symptoms of shock from old insulin are nervousness, headache, tremor and sweating; from protamine-insulin are stupor, headache, nausea and vomiting. The latter may be the same as coma of diabetic acidosis.

Dr. Ohler recommended an article from the Lahey Clinic in the March 11th issue of the *New England Journal of Medicine* on Thyroidectomy in Heart Disease; also an article on Postural Hypotension in the February issue of *Archives of Internal Medicine.*

Rhode Island Hospital

CALENDAR FOR APRIL, 1937

1. Executive Committee of Staff ..... 12 noon
1. Gynecologic Staff Meeting ..... 8:30 P. M.
2. Urologic Staff Meeting ..... 7:30 P. M.
2. Surgical Staff Meeting ..... 8:30 P. M.
11. Quarterly Meeting of General Staff ..... 12 noon
11. Pediatric Staff Meeting ..... 8 P. M.
12. Clinical-Pathologic Conference ..... 12 noon
12. R. I. Society for Neurology and Psychiatry ..... 8:30 P. M.
15. Executive Committee of Staff ..... 12 noon
26. Clinical-Pathologic Conference ..... 12 noon

Mondays and Tuesdays: 10:30 A. M., Surgical Grand Rounds and Round Table; first and second divisions alternate

Tuesdays: 7 P. M., Internes' Pathologic Conference

Wednesdays: 10 A. M., Tumor Clinic

Thursdays: 9 A. M., Orthopedic Grand Rounds

Fridays: 11 A. M., Fracture Rounds; 11 A. M., Pediatric Grand Rounds; 11:30 A. M., Heart Conference

Saturdays: 10 A. M., Medical Conference

March 5. At the regular monthly meeting of the Surgical Staff, Dr. Nat. H. Gifford presented a case of congenital atresia of the common and cystic bile ducts, amenable to operation, in a patient four weeks old. Choledochoduodenostomy had been performed four days before. A standard nomenclature for operations, following the list of the Western Surgical Association, was adopted.

Dr. Gayton S. Bailey, of Seattle, Washington, and Harvard Medical 1934, who interned at the Rhode Island Hospital from December 1934 to January 1937, on March 1st, 1937, became House Physician. Previous to his doing so, Dr. and Mrs. Bailey paid a visit to his home in Seattle, Washington, and returned to Providence by way of California.

Dr. R. L. Garrard, who interned at the Rhode Island Hospital from 1933 to 1935, has been appointed Superintendent at the State Sanatorium at Wallum Lake. Dr. Garrard had been connected with the institution for about a year.

Dr. Robert G. Murphy has opened an office for the practice of internal medicine at 221 Thayer St.

Dr. Luther McDougal finished his internship March 1st.

Dr. Raymond Moore, of Groveland, Mass., Wesleyan University and Tufts Medical 1937, started internship at the Rhode Island Hospital March 15th.

Dr. and Mrs. Robert Baldridge and Dr. and Mrs. Herman Lawson have returned from a trip to the West Indies.

Dr. William Magill is vacationing in South America.

Word has been received here of the marriage of Dr. Pat Imes. Dr. Imes interned at the R. I. H. during 1928 and 1929. At present he is residing in Louisville, Kentucky.

Word has been received of the birth of a son to Dr. and Mrs. Allan Tuggle. Dr. Tuggle was an intern at the R. I. H. in 1927.

The following former interns at the R. I. H. have been licensed to practice medicine in Rhode Island:

Dr. Henry George Atha, Thomaston, Conn.

Dr. John Stanislaus Dziob, resident physician, Jane Brown Memorial

Dr. Edward B. Medoff, Woonsocket, R. I., at present at the R. I. Hospital

Dr. Thomas A. Martin, Intern, R. I. H.

Dr. Robert F. Nuessle, State Infirmary, Howard, R. I.

Woonsocket Hospital

The regular Staff Meeting was held February 1, with President T. Frank Kennedy presiding.

Dr. Leo Dugas was elected to the Out-Patient Staff.

The Medical Records Committee reported improvement in writing of records and in the caliber of both the Staff Meetings and Clinical Conference.

Dr. J. Edgar Tanguay read a paper on "Dizziness."

A motion picture film on the "Management of Pneumonia" was shown by Dr. Roberts through courtesy of the Lederle Laboratories.

The monthly Clinical Conference was held February 22. Dr. Henri E. Gauthier, Chairman of the Records Committee, presided.

A very interesting case was presented by Dr. G. G. Dupre and discussed by Dr. John V. O'Connor. The diagnosis of this case was not definitely determined but will be further discussed at the next meeting.

Dr. J. B. Riley presented the second case, that of severe Rheumatic Fever in a child of 5 years of age. The discussion was made by Dr. Thomas J. Lalor.

Memorial Hospital

Dr. Thomas P. Sheridan has been appointed to the Pediatric Clinic of the Out-Patient Department.

Plans are underway for the formation of an up-to-date library for the visiting and house staff.

The chiefs of service held a meeting recently to formulate plans for the Interne Alumni Clinic Day together with discussion of ways and means of improving the various clinical services.

Dr. George H. Alexander has been granted a year's leave of absence.

At the clinical pathological conference held on March 10, Dr. E. R. White presented a case of hydrocephalus and tuberculous meningitis. The case was discussed by Drs. E. F. Kelly, J. F. Kenney, A. A. Bertini, E. W. Benjamin, T. A. Krolicki and E. J. Mathewson. Dr. Laurence A. Senseman presented a case of strongyloides stercoralis found in appendix. The case was discussed by Drs. J. F. Kenney, J. E. Kerney, M. A. Chapian, E. R. White, A. A. Bertini and E. J. Mathewson.

St. Joseph's Hospital

The monthly meeting of St. Joseph's Hospital Staff Association was held at noon on Thursday, March 11. Dr. Oliver Cope of the Department of Surgery of the Massachusetts General Hospital read a paper on the "Significance of Amenorrhoea in Endocrine Diagnosis," illustrated with lantern slides. Collation was served.

Dr. Torr Wagner Harmer of Boston will present a paper on "Hand Infections and Injuries" at the Monthly Staff Meeting, April 8.

The day for Open House—combined rounds of the Medical, Neurological and Cardiological Departments, has been changed to Friday. Rounds will start in the Out-Patient Department at 9:30 A. M., and proceed through the wards.

Dr. William J. Schwab, who completed a two year rotating internship in 1935, has opened his office at 616 Hope Street, Providence, R. I.

Dr. Donald B. Moore, who has recently completed a two year rotating internship, has been appointed as Resident Obstetrician for the coming six months.

Minutes of the Caduceus Club

The monthly meeting of the Caduceus Club was held at the T. K. Club on March 8. The meeting was called to order by President Earl J. Mara. The report of the Secretary was approved as read. On motion by Dr. Kelly, it was voted that after the final lecture the present series be discontinued until next fall.

Discussion on the school health department was opened by Dr. Krolicki. A special Committee was appointed by the President to draft recommendations for the improvement of the school health department. The Committee consists of Thad. A. Krolicki, Robert T. Henry and Edward McCaughey.

The recommendations of the Committee were as follows:

1. A course in first aid for emergencies which arise in the schools, to be taken by all school teachers.
2. Elimination of group pre-school examinations in favor of a complete physical examination by the family physician according to the requirements of the National Parent-Teachers' Association, but modified to permit the examination of children without fee in the event parents are unable to pay.
3. Elimination of physical examinations by teachers, as of eyes and feet, the same to be done by the school nurses under supervision of the school physicians.
4. Elimination of treatment of pupils by school teachers except in emergencies requiring first-aid.
5. Cases of illness or injury among pupils to be handled by family physicians.
6. Evolution of some method of checking absentees to determine whether they are suffering from contagious disease.
7. Placing of school nurses under the direction of school physicians, the nurses to act on order of the physicians and not on order of the school officials.

8. Full authority for school physicians to decide whether or not a child should be accepted for the open-air school.
9. Establishment of special grades for backward children in various districts.
10. Standard first-aid equipment for each school, such equipment to be used under the supervision of the school physicians.

These recommendations were tabled for final consideration at the next meeting. Following a collation, the meeting was adjourned.

Respectfully submitted,

GEORGE B. MCCLELLAN, M.D.,
Secretary.

RHODE ISLAND SOCIETY FOR MENTAL HYGIENE

Report of the Annual Meeting

RHODE ISLAND COLLEGE OF EDUCATION

FRIDAY, MARCH 5, 1937 4:00 P. M.

PROGRAM

DR. ARTHUR H. HARRINGTON, Superintendent Emeritus, State Hospital for Mental Diseases, *Chairman*

DR. ARTHUR H. RUGGLES, President, National Committee for Mental Hygiene, *"What Can Be Done Toward Prevention"*

DR. EVELYN ALPERN, Medical Director, Providence Child Guidance Clinic, *"The Providence Child Guidance Clinic"*

DR. FRANK J. O'BRIEN (Guest Speaker), Acting Director, Bureau of Child Guidance, Board of Education, New York, *"Child Guidance and Education in the Schools"*

Dr. Harrington, as chairman, opened the meeting with a brief history of the Society, commending its attainment of chronological maturity by touching on many of the important measures toward increased community consciousness of the problems of mental health which have developed during the Society's twenty-one year period of adolescence. He stressed that, although the R. I. Society for Mental Hygiene may look back with a sense of accomplishment, the present picture does not allow for a feeling of settled satisfaction.

Dr. Ruggles, in recognizing the progress which has been made, pointed out that the expenditure of approximately $4,000,000 for the construction of new buildings at the State Institutions does not solve the problem of mental disease. The time has come when we must realize that the solution to the problem lies not only in expenditures for buildings and equipment, but also in the matching of these dollars to supply the brains necessary to adequately manage and staff these buildings for research and study into the situations which increase the need for these buildings; and for progressive education, which shall be not simply the imparting of information but which shall lead to a true development of the child's total personality. This is a problem which cannot be handled by one group or one district but must be met by co-operative effort and sacrifice on the part of parents, psychiatrists, the church, schools, and social organizations.

Viewing the problem of mental health from the angle of the school and the clinic, Dr. O'Brien pointed out that undesirable behavior on the part of an individual is an indication that this human being is unable to get along. Frequently the home and the school fail to recognize that the too-good child who receives A in conduct and studies is in reality living out an undesirable form of behavior which society through the courts and its penal institutions is forced to deal with in later years. It is not the 39 children in a classroom that fill our reformatories, but the 40th odd child. The school must meet this challenge and assume full responsibility for the development of this odd child.

The school, if it is to adequately meet the needs of the child in developing his total personality cannot lend itself to license and lack of discipline on the one hand, nor can it maintain a dictatorship in which military discipline and clock-work precision are the rule. The good school follows a middle course which allows for growth within defined limits. Strangely enough, the emphasis in choice of teachers and principals is upon qualities of leadership—an emphasis which has often resulted in the choice of aggressive people for positions in which aggression can be more of a handicap than an asset. It is more important for the growth of the child that his teacher be a happy, healthy individual, than one possessed of advanced degrees and high scholastic standing.

Referral to a clinic does not mean an admission of failure on the part of the school, the teacher or the principal. A good doctor does not hesitate to call in a specialist when the patient's health indicates. A good educator, in dealing with serious personality problems, seeks the help of the specialist in that field, the psychiatrist.

Dr. Alpern described the functioning of the Providence Child Guidance Clinic as follows:

The Providence Child Guidance Clinic is a clinic for the psychiatric treatment of the behavior problems of childhood. (Clinic service is limited to those individuals who are not able to afford the services of a private psychiatrist.) This clinic, like every other child guidance clinic, operates through the use of a philosophy of helping human beings in emotional difficulty which is carefully tested by us, as it is and has been by leaders in the child guidance field throughout this country. This philosophy, for us, is centered around our understanding of the factors involved in bringing about change in a human being. Why do human beings change? Our understanding of this important psychological phenomenon in the life of an individual is vital for our effective functioning.

We may consider the phenomenon of change in relation to what happens when a parent brings a child to the clinic. The parent, more frequently the child's mother, may come to us because she is seriously troubled about some phase in her child's personality growth and development. In seeking help for this problem, her physician, perhaps, or the child's school, perhaps, has told her that the clinic may be able to help her in the working out of the problem. A mother may come on the other hand, because people she knows are critical because of the way her youngster behaves. They may criticize the mother herself because of the way in which she brings up the child. A mother may, therefore, come to us, in this instance, not so much as an individual seeking help, but as an individual seeking vindication or justification for herself. Her thinking may be something like this, "I'll show them all how smart they are. I'll take Johnny to the Child Guidance Clinic, but the clinic cannot help him, I know. I'll show them that everything is being done that can be done, and that if I cannot make Johnny good, no one can."

These two brief examples illustrate two of the many and varied kinds of feelings about their child's problems that a parent may bring with him when he comes to us. What happens when the parent does come to the clinic, and what is it that can make for change in a troublesome and often seriously pathological situation?

We know that a fundamental factor in motivating change in a human being is inner desire for change, inner dissatisfaction with ourselves as we are. This desire for change is never a one-sided feeling. Like most human emotions, it is double-edged. On the one hand, we wish for change; on the other hand, we cling desperately to what we are, which carries with it the known, the safe, the residuals of our past living and our present strivings. Most important of all, what we are now and what we have achieved as we are now, represents something that is our own, and because of this has unique value for us.

In our work with parents, as well as with children, we respect that what the parent and child brings to us carries with it the integrity of the individual. This integrity must not be violated if the parent or child is to obtain psychological help. We can appreciate the individual's need to cling to the old self as well as his wish for change in that self. A sturdy bulwark in our treatment armamentarium therefore becomes this: We can accept the individual as he is when he comes to us, troubled, confused, angry, bitter, disappointed, or whatever the case may be. Concretely, let us suppose that a mother comes to us saying: "I don't know what to do about Sally. I've tried everything. Sometimes I wish that she had never been born. Sometimes I wish that I had never been born." What do we say to this mother. We say this, in effect, as treatment progresses: "In this clinic we can give you an opportunity to re-experience in a neutral atmosphere some of these things that trouble you. You tell us that you wish your child had never been born. We shall not criticize you for this nor shall we condone you. This, we know, is what you feel at this moment. This feeling is at this time a very real part of yourself. It may not be all of you. Our interest in you is in helping you to think out with us what you can do about all this." This approach utilizes our understanding that maximum psychological help comes out of helping an individual to do as much as he is able at a particular time. Our interest becomes focussed in this, rather than, through cajoling, persuading, threatening or punishing, in trying to get him to do what we think best. We can be content to withhold this authoritative kind of approach, because we utilize in our thinking the studies that have been made that have to do with emotional growth. We know from these studies that in each human individual there are strivings toward maximum emotional growth or maturity. Our interest becomes centered, then, around offering a medium through which an individual may strengthen his own tendencies toward emotional growth and maturity.

In addition to help offered parents, the clinic offers psychiatric treatment for children. This treatment, too, is centered around offering the child an opportunity for further emotional growth and development. We find that even at times very young children can make use of this kind of treatment. Younger children are given an opportunity to work out their feelings about things through the medium of play, the natural mode of expression for the child. Toys are utilized not for the pleasure value of play but as a vehicle through which the child may express his emotions. Through this kind of play, which the psychiatrist can understand, the child, too, may achieve some better balance in his emotional life at the point at which he is blocked. We interpret a child's difficulties in behavior, such as truancy, wetting, sex difficulties, temper tantrums, as evidences of blocking in his emotional growth, and through the use of treatment may be able to give him an opportunity for an impetus toward the healthy resumption of growth. Here, too, we are interested not in disciplinary, punitive, or pedagogical measures. In some instances it becomes necessary to help in planning for certain modifications in the child's environment, to enable him to best use what he has gained from clinic treatment.

In conclusion, then, the Providence Child Guidance Clinic represents a place where both parents and child, in those instances when there are difficulties in the child's living, either with himself or with others, as evidenced by his behavior, can find through the professional help of the clinic staff an opportunity for working toward further self development.

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RECENT BOOKS

A Hand-book of Ocular Therapeutics. By Sanford R. Gifford, M.A., M.D., F.A.C.S. Second Edition, thoroughly revised, 341 pages, illustrated with 60 engravings. Cloth, $3.75. Lea & Febiger. Philadelphia, 1937.

This is a concise book on therapeutics in which an attempt is made to present only the most valuable procedures.

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The book is compact, well-arranged, clear, logical and sane. It is becoming the standard work on its subject in this country.

Harry C. Messinger, M.D.

Synopsis of Ano-Rectal Diseases. By Louis J. Hirschman, M.D., F.A.C.S., pp. 288, with 174 text illustrations and 6 color plates. Cloth, $3.50. St. Louis, The C. V. Mosby Company, 1937.

This book is the fifth of a line issued by the author since 1909 in an effort to bring to medical students and general practitioners a condensed work adaptable especially to the needs of the latter. Following consideration of the main points of anatomy, the book treats of the diagnosis and care of diseases that one would meet in the usual day's work: hemorrhoids, fistula in ano, infections of the bowel, functional disturbances, constipation and related conditions. Local anesthesia, the use of which the author feels would allow for many ordinary complaints to be handled satisfactorily in the office, is given considerable attention. He stresses the need of complete local examinations when symptoms point to ano-rectal disease, citing the too frequent pitfall of finding malignancy long after treatment for some benign condition has been instituted. He thinks also that better handling of these conditions would keep many patients out of the hands of the pseudo-scientific practitioners. The book is interesting, compares favorably with like treatises, and is recommended to those interested in this work.

James H. Fagan, M.D.

Medical Morals and Manners. By Hubert Ashley Royster, M.D. 333 pages, Cloth, $2.50. Chapel Hill, The University of North Carolina Press, 1937.

The author of this volume is a distinguished physician; a man whose literary efforts and professional achievements have earned for him an enviable reputation. The present volume is essentially a collection of his numerous essays and addresses written over a period of many years. Medical colleagues, as well as the medically minded public, will find the assembled papers enjoyable and instructive reading.

The author writes of many subjects, varying in character from interesting reminiscences, short biographical sketches of the great masters of early American medicine, chapters devoted to the betterment of the public's medical welfare, and subjects chiefly of interest to physicians.

It is gratifying to feel that this book was not published with the intent that it should become another medical "best seller." Instead, it is written in an informal but vigorous style and contains not the dramatic or spectacular, but the sound logic of a physician who for over forty years has contributed much of value to our profession.

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Report of the Providence Tuberculosis League

A Review of Sickness Insurance in Foreign Countries, by Dr. Herman C. Pitts

Brucella Infections in Man, by Dr. Cecil C. Dustin

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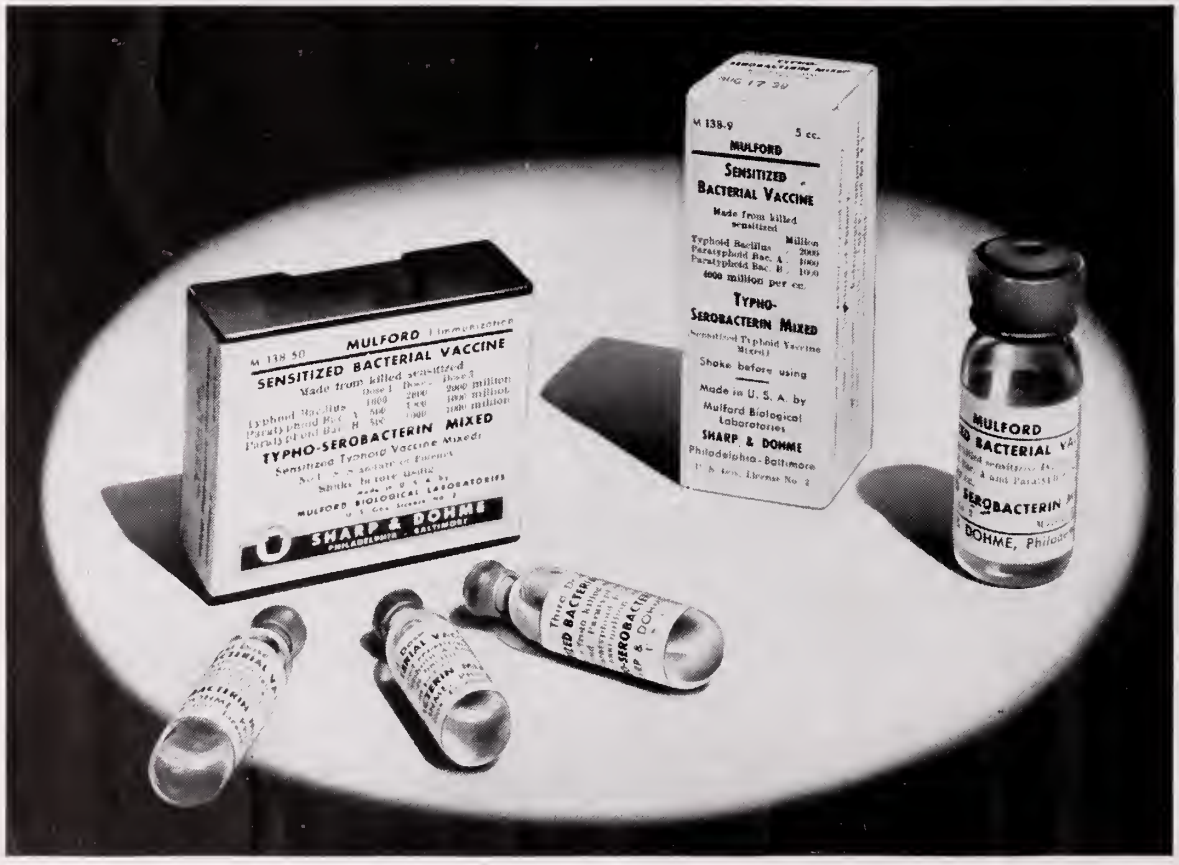
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III. VITAMIN A

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Minimum human requirements for vitamin A are influenced by such variables as size of the individual and efficiency of absorption. The minimum daily requirement of infants has been estimated at 1500 International units, based upon the vitamin A content of milk. The need for the vitamin is not supplied by 1200 International units, while 2000 International units appear to be sufficient (2).

Although the minimum requirement of the adult has been estimated to be as low as 500 International units, the optimum level for both older children and adults is probably between 3000 and 5000 International units per day (3). The League of Nations Technical Commission recommends over 5000 International units of vitamin A for the pregnant and for the lactating woman (4).

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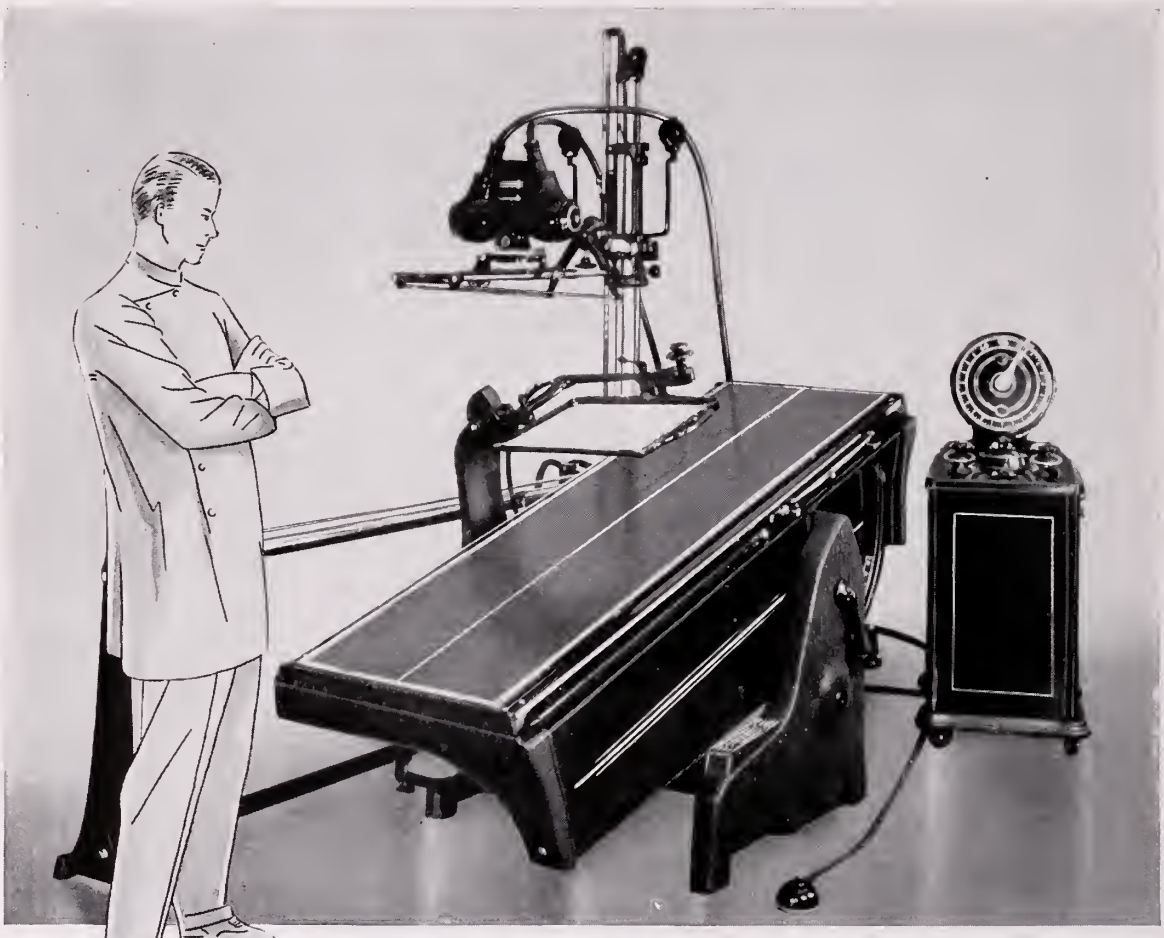
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(1) a. 1935. J. Am. Med. Assn. 105, 1608
b. 1936. Ibid. 106, 996
(2) 1934-35. Am. Pub. Health Assn. Year Book, Page 70.
(3) a. 1934. J. Am. Dict. Assn. 10, 296
b. 1936. Indian J. Med. Research 23, 741
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(5) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 364. MacMillan. New York.
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b. 1933. J. Am. Dict. Assn. 9, 295
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b. 1933. Georgia Expt. Sta. Bull. No. 177
c. 1936. J. Am. Dict. Assn. 12, 231

This is the twenty-fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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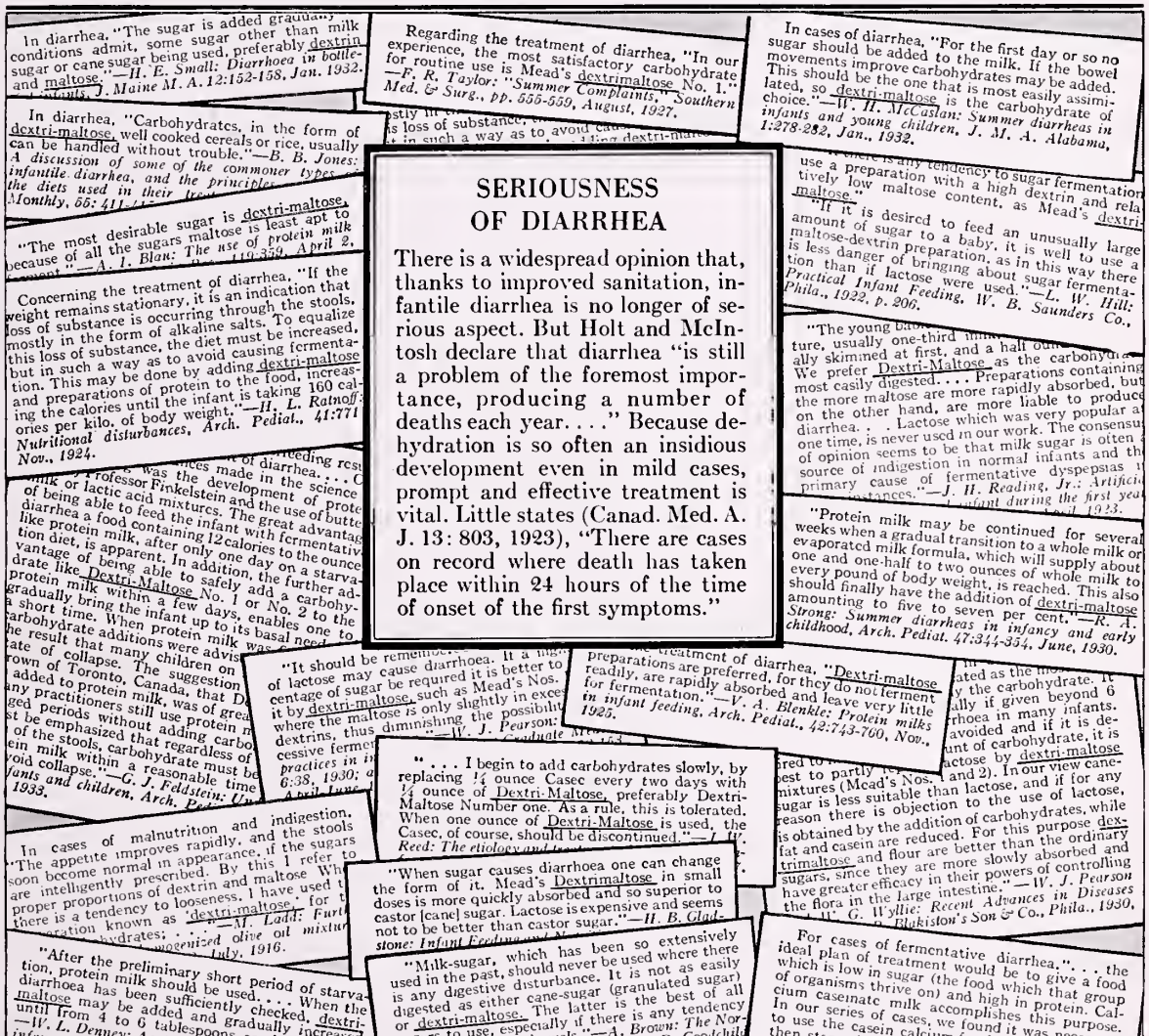
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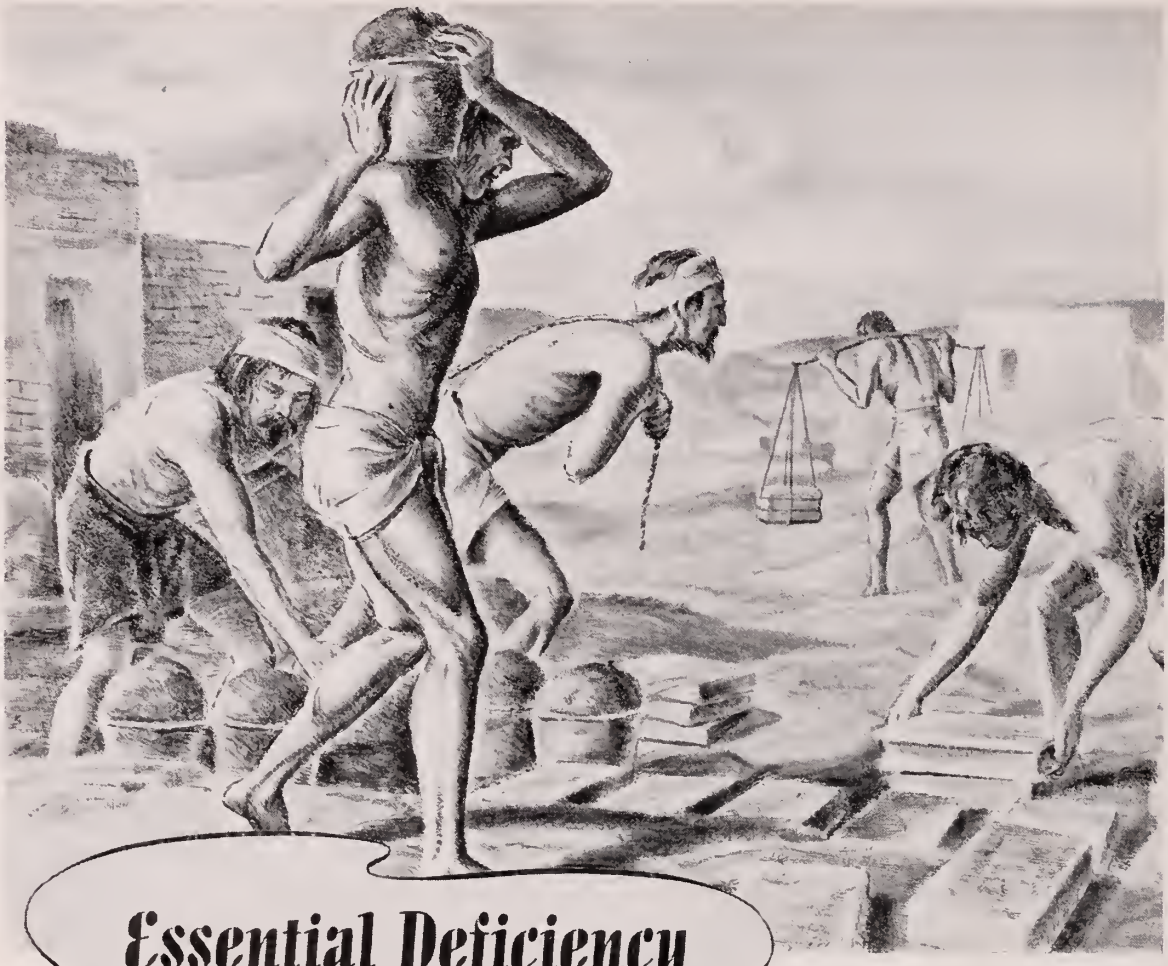
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THE RHODE ISLAND MEDICAL JOURNAL

Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 5 | Whole No. 332 | MAY, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

BRUCELLA INFECTIONS IN MAN

CECIL C. DUSTIN, B.S., M.D.

199 THAYER STREET, PROVIDENCE, R. I.

Although the International Medical Congress in 1913 agreed upon the name "undulant fever," this term is not advisable in the United States because the type of fever is not pathognomonic for the infection. It is quite evident that the disease takes a different form from the infections commonly seen in the South European countries. The reason for this difference in the clinical course of the disease seems to be in the origin of the infection. In the Mediterranean regions the disease is mainly contracted from the ingestion of goat's milk and of goat milk products. In this country the disease appears to be more frequently contracted from cattle and swine.

The disease has probably been endemic about the Mediterranean for centuries, but the first cases recognized in this country were found in soldiers returning from the Philippine Islands at the close of the Spanish-American War. The first case definitely known to have originated in this country, was reported by Craig in 1905. However, it is quite probable that, prior to this date, the disease was already well established in Texas, where importations of goats had been made.

In the past few years, the disease has been reported from every continent, and from a majority of the countries of the world. In the United States prior to 1925, only about 128 cases of undulant fever were reported, and they were regarded as clinical curiosities. During the years 1927 to 1930, the recorded cases numbered 217, 649, 1,301, and 1,385 respectively. During 1929, Brucelliasis was encountered in every state in the Union. During 1931, 1932 and 1933, 4,336 cases of undulant fever were officially reported, and the disease is reportable in 40 states. It is recorded that 9,965 cases have been reported up to January 1st, 1935. The disease is rapidly increasing. This disease is considered one of the most serious facing public health officials today, because of its widespread occurrence in three important domestic animals. The organisms may be present and multiply in the blood, genito-urinary tracts, and milk ducts of goats, swine and cattle. It has been asserted that, in some instances, dogs, cats, rabbits, guinea-pigs, rats, mice, chickens, and ducks have revealed natural infections. It would be expected that the widespread presence of the disease in domestic animals would result in a much higher rate of infection in man. However, it has been quite definitely shown that human susceptibility to the bovine Brucella is low.

There are, apparently, three types of causative organisms, and the disease may be contracted from goats, swine, or cattle. Bacteriologically, the bovine type of Brucella is more difficult to isolate than are the Brucella of caprine or porcine type. In all varieties the growth is slow, and, previously, probably many cultures were discarded before sufficient growth had taken place to allow a diagnosis. No easy, certain way of differentiating these organisms has been devised, and the identification is laborious. Brucella is somewhat resistant outside the body, withstanding desiccation from sixty to eighty days. It lives in tap or sea water for about a month, and has been found to survive in a dry condition for a period of two to three months. It is readily killed by sunlight. In alkaline urine, the organisms have been found alive after six days; in acid urine, for as long as sixteen days. Brucella may remain viable in moist manure for seventy-five days, and it has been known to survive for one hundred forty-two days in butter stored at 8° C. In cream, it survives for about ten days. It has not been found to multiply in nature outside the body. It has not been found in dust or air from infected rooms. Pasteurization of infected milk renders the milk safe for human consumption.

Barnet was unable to infect man or monkeys by subcutaneous inoculation with Brucella abortus (bovine), although controls were readily infected with Brucella melitensis (goat). In this connection it is of interest to note that, in the human infections in Iowa, Hardy examined from many angles the

Read before the Providence Medical Association, April 5, 1937.

clinical records of the patients from whom Brucella had been isolated, in an endeavor to determine the relative virulence of the abortus and suis varieties for man. Those patients from whom an organism was isolated were divided according to the severity and duration of their symptoms into four categories: (1) fatal; (2) severe or moderately severe; (3) mild; and (4) ambulatory. From each of the three fatal cases a suis variety was isolated; from one of them, an abortus as well. From twenty-eight in the second category, twenty-three suis and five abortus cultures were obtained. The mild cases yielded four suis and three abortus; and the ambulatory, three suis and five abortus strains. Thus eight of the fourteen abortus strains were derived from mild and ambulatory infections, while 23 of 26 suis strains were from severe or fatal cases. However, in an Ohio investigation, the four strains of Brucella recovered, one from human blood and three from cow's milk, were found to be of the bovine variety. Many epidemiologists believe that the bovine variety of Brucella is the primitive type, and that the suis and melitensis and paramelitensis varieties have been derived by modification from passage through swine and goats, thus increasing their virulence.

A study of large groups of cases of Brucelliasis would indicate that the drinking of milk from infected herds is a relatively minor source of infection. Apparently the disease is much more frequently acquired by contamination of the abraded skin with blood or excreta from infected animals. At the time of abortion, the organisms occur in large numbers in the uterine discharges and udder ducts. Cows may act as carriers for years. Bulls may also carry the infection, particularly in the seminal vesicles. Cows seldom show the Brucella in the blood and urine. In the goat, the opposite is true; that is, the organisms are found in large quantities in the urine and milk of goats, and at times in the blood. Infected sheep are known to excrete the organisms in the urine. The genital secretions of infected hogs are rich in organisms. Thus there are many sources for easy infection among persons handling domestic animals. The infected human may be a source of infection to others. The urine appears to be the chief path of exit for the Brucella in man. The organisms excreted may vary from a few to many, and they may be recovered in some cases, even 2 years after the patient is convalescing. The organisms have been demonstrated in the feces, but the rapid growth of other organisms present makes its isolation difficult. Organisms have been isolated from the gall bladder and from human milk; thus the possibility of human carriers for this disease is considered likely. The danger of nursing cases, particularly when abrasions are present on the hands, must be recognized. It has been pointed out that while undulant fever is not generally transmitted directly from the sick to the well, in some fever hospitals, the nurses and attendants are 10 times more liable to contract the disease, than people not so employed.

The portal of entry may be the alimentary tract or any mucus membrane, as it has been demonstrated that Brucella can penetrate normal mucus membranes of the naso-pharynx, eye, and genito-urinary tracts in man. Skin abrasions are a common means of entry. Although mosquitoes have been shown to harbour the organism, there has been no evidence that insect bites may infect humans. The intact skin is believed to be possibly penetrable by Brucella.

The disease is rarely found in children under 12 years of age, the majority of cases being in young and middle-aged men. Occupation plays a definite role in etiology, because of the opportunities it provides for infection. Generally, the incidence of the disease is greater in smaller communities, probably because of greater opportunity for contact with infected animals, and the more general use of raw milk. In this country, the summer months seem to show a higher incidence of the disease.

There is nothing pathognomonic of the gross morbid anatomy of undulant fever. Probably all cases have a septicemia of some duration.

Apparently the incubation period for Brucelliasis is from five to twenty-one days—the average being two weeks. In those cases where the portal of entry has been known to be an abrasion of the skin or mucus membrane, the period is shorter than when the organisms have been ingested. The onset is usually insidious, and the prodromal symptoms, the febrile reaction, and the duration of the fever vary greatly—depending upon the virulence of the infecting organisms. Occasionally, the disease is initiated with a chill and a rapid rise in temperature. Ordinarily, however, the patient becomes gradually aware of an afternoon or evening rise in temperature, associated with chills, nocturnal perspiration, and marked weakness. In the chronic,

nearly afebrile cases, this marked weakness and nocturnal sweating are the most characteristic symptoms. The patient usually feels quite well in the morning, particularly in the early stages of the infection. As the daily rise in temperature develops —usually in the afternoon or early evening—the symptoms return. The temperatures occasionally reach peaks as high as 106° F.—but the average maximum fever is 103° F. There is often a marked disparity between the subjective sense of feverishness, and the extent of fever as registered by the thermometer. In many instances the patient does not complain of fever and does not present a febrile appearance. As the fever abates, chills and sweating occur. True rigors occur in about two-thirds of the cases. Recurring relapses of fever are certainly not the rule in the cases described in the United States. There are some cases that are nearly afebrile, and these are apt to be very chronic, lasting several months. In these cases, the use of vaccine intramuscularly as a diagnostic procedure is most helpful. In the afebrile cases, joint and muscle pain, and marked weakness, are the outstanding symptoms. These cases are most often confused with rheumatic conditions.

Constipation is a fairly constant symptom, and its degree seems to parallel the severity of the infection. Diarrhea is of rare occurrence. Loss of weight is an almost constant feature of the disease. Aside from such signs as fever, weakness, and loss of weight, there is often a remarkable absence of positive physical findings. The spleen is palpable in only one-third of the cases, and joint and muscle tenderness is present in about one-third of the cases. Abdominal pain is a prominent complaint, early in the disease—in about ten per cent of the cases. This has led to unwise surgical intervention in some cases. There is some evidence that Brucella infection may be a factor in certain cases of abortion in women.

Blood studies usually show a secondary anemia, the degree depending upon the severity of the illness. The majority of the cases exhibit leucopenia, with the white cell count below 6,000. A relative lymphocytosis usually occurs, and many of the lymphocytes are young forms, a fact which is of some help in differential diagnosis.

If Brucella infection is given consideration in the differential diagnosis of all cases of febrile illness, particularly in those that tend to show chronicity, the disease will be recognized with much greater frequency. In such case it should be the custom to collect four or five c.c. of the patient's blood for the agglutination tests. The blood is taken exactly as it is for the Wasserman test. The rapid macroscopic agglutination method of Huddleston is a simple and reliable procedure. The agglutinins are usually present in sufficiently high titer to give a positive reaction by the second week of the disease. There is convincing evidence that about five per cent of individuals with Brucella infection do not develop anti-abortus serum agglutinins.

In doubtful cases showing a negative agglutination test, an intradermal test should be tried. This test is done by injecting intradermally one-tenth of one c.c. of commercial bacterial vaccine. A positive reaction is characterized by the appearance, at the site of injection within forty-eight hours, of a raised red indurated area about 1 c.m. in diameter. Occasionally a small sterile pustule will develop in the center of the indurated area. Another test of the diagnostic value is the reaction to the injection, intramuscularly, of a small amount of commercial vaccine. In doing this test, about one-half a c.c. of vaccine is injected intramuscularly. The non-infected individual will show practically no general or local reaction, while the infected patient will usually show a rise in temperature of two degrees F. and local swelling and soreness. There is apparently no danger of undesirable reactions from this test. If the test is to be made on a febrile case, the injection should be given during one of the afebrile periods. Since a bacteremia is present in this disease, an attempt to recover the organisms by blood cultures should be made, whenever possible.

The disease in this country has shown a low mortality, death occurring in only about one per cent. of cases reported. The importance of the disease is not to be judged by the death rate, but rather by the prolonged invalidism. The most important consideration in the control of Brucella infection is prophylaxis.

Treatment in Brucella infection should be essentially directed at relief of the prominent symptoms. A high calory diet is important, and the constipation can usually be controlled by the use of fruits and the milder laxatives. Heat has been found to be most efficacious in relieving the joint and muscle pains. Heat is also useful in relieving the abdominal

pain, when it occurs. Many materials, such as neoarsphenamine and mercurachrome intravenously, have been advocated—but there is no real evidence that any of them have true therapeutic value. Many observers have reported favorable results with specific vaccine therapy, and there are case reports in sufficient numbers to indicate that its use is justified. Apparently, vaccine therapy shortens the course of the disease and tends to prevent recurrence. Brucella infection is often characterized by natural remissions, and the value of any therapeutic measure must be interpreted with caution.

Discussion

Dr. Wellman: Dr. Dustin's paper has left little of clinical importance for me to add. One point of interest is the length of time required for classification of the organism. In 1887, David Bruce demonstrated the organism causing malta fever, which he named "micrococcus melitensis." In 1897 Bang discovered the causative organism of contagious abortion of cattle, which he called "bacillus abortus." It was not until 1918 that Alice Evans discovered that the two organisms are indistinguishable morphologically, culturally and by ordinary agglutination tests. This meant reclassification of the abortus melitensis with the generic name "brucella" given to the group. Undulant fever presents difficulties in differential diagnosis due to its similarity to typhoid, malaria, tuberculosis and influenza. It is less often confused with acute rheumatic fever, subacute bacterial endocarditis, bronchitis, pyelitis, appendicitis, cholecystitis or tularemia. Agglutination tests vary. For practical purposes, diagnostic significance is usually attributed to agglutinations in dilutions of 1 in 80 or above. Occasional cross-agglutinations of brucella and bacterium tularense should be borne in mind. It has been suggested that all serums from suspected cases of undulant fever and tularemia should be tested for both antitularense and antiabortus agglutinins. If the titres are the same, agglutinin absorption tests will distinguish them. Regarding therapy, Drs. C. E. Irwin, H. P. Hunt, and J. S. Niles, Jr., have reported successful results in twelve cases treated by intravenous administration of mixed typhoid vaccine. Each cc. contained 1000 million typhoid bacilli and 50 million each of paratyphoid A and B. The initial dose of 50 million killed organisms was repeated every five days until four to six treatments had been given, the dose being increased 25 to 50 million each time. They believe the injection stimulates a general non-specific immunogenic reaction.

Dr. Bates reported that all certified milk sold in this area is free from brucella infection.

Dr. Chafee emphasized the prevalence of the disease in this locality. It should not be forgotten in the presence of any low grade fever.

Dr. Dustin: The disease is much more important than we realize. It is often not diagnosed. It is a long drawn out disease with an average duration of three months when untreated.

A REVIEW OF SICKNESS INSURANCE IN FOREIGN COUNTRIES

Herman C. Pitts, M.D., F.A.C.S.
68 Brown Street, Providence, R. I.

Even the youngest of us present here tonight has lived to see a greater advance along the line of socialization of Government in this country than occurred in all of the earlier part of its existence. Some of us may approve of the Social Security Act, the Old Age Pensions, and the hundred and one other acts that have allowed Government to interfere seriously in the private lives of each and every one of us—some of us undoubtedly do not approve. But whether we approve or no, the Government has interfered, is interfering, and apparently will continue to interfere more and more. It stands to reason that this ever expanding circle of socialization will sooner or later engulf the medical profession and all its works. And this will happen whether the medical profession likes it or not.

For the medical profession plays too important a part in the life of the whole nation—there is too large a sum involved the country over, and too many people feel the pinch of bills contracted during illnesses that certainly the Doctor did not create—although he has been accused of doing so. Granted that from the point of view of the majority of the profession our present system works satisfactorily enough. How does that help? Was the business man consulted when N.R.A. was sprung on an unsuspecting world? And what if it was declared unconstitutional—something else of the same nature will be tried in the not distant future. Then the silly tampering with the fundamental laws of supply and demand in the killing of hogs and cattle and the paying of the farmer not to plant corn and cotton. All these of course are part and parcel of the gradual assumption of control of Government in every sort of human activity. With so many examples of the trend of the times glaring at us from every side, doesn't it behoove us to come out of our ostrich-like attitude—face the facts, and be prepared in a measure to direct the course of events? To do this properly we must know how other nations are attempting to solve the same problem, weigh their different methods, and then when the time arrives have something constructive to offer that we can direct.

It may be news to you—it certainly was to me—to learn that every single one of the presumably

Read before the Providence Medical Association April 5, 1937.

unenlightened, backward European nations has some sort of sickness insurance. Many of the schemes date back a good many years. Germany's first attempt, for instance, began in 1883. And interestingly enough, the scheme was put forward by Bismarck to still the clamor of the Socialists and forestall their demand for something more radical. Austria and Hungary fell into line in 1888 and 1891, and since then each and every European nation has adopted some form of sickness insurance. As time has gone on, the scope of the laws has widened, but practically all have the same provision of compulsory insurance against sickness among all wage earners, whose wages fall below a certain amount.

In reviewing this subject, I have chosen two countries as representative, Great Britain and Denmark and will try to give the salient points of the working of the law in each. Before Great Britain tackled the insurance problem, sickness benefit was in the hands of the usual benefit societies just as it has been here and probably worked no better there than here. In 1911 Parliament passed the National Insurance Act, which became effective in 1912. This act provided for the compulsory insurance of all workers 16 years of age or older who earned 160 pounds or less a year. A Ministry of Health was created which acts as a final arbiter in all disputes. Since the act was passed, many changes have been made, one of most importance being to include in the scheme those workers earning up to 250 pounds a year.

The Act provides that the insured male contributes the equivalent of 9 cents a week; a female, 8 cents; the employer 9 cents for each; and the Government one-seventh of the cost of cash benefits and local administration for the male, one-fifth for the female, and the entire cost of central administration. Medical attention is in the hands of medical men in each community who are registered practitioners and express a desire to serve. Their names are put on a panel in that community and the practice is spoken of as "panel practice."

When a doctor places his name on the "panel," he is, naturally, sooner or later consulted by a varying number of insured persons, depending very often on his popularity. These persons are placed on his list and the names as they accumulate are sent in to a committee. He is allowed to have as many as 2500 names on his list. His yearly stipend is based on the number of names on the list. His per capita income as based on this list is small—only 9 shillings or about $2.25 per person, but since it has been shown that the average yearly attendance per person is only 2.3 office calls and 1.2 home visits, the average amount received per visit compares very favorably with the amount received per visit by doctors not on the panel, practicing in the same community. The total income is quite sizable and, furthermore, that income is certain; there are no dead heads and consequently no bad accounts accumulating year after year. A panel doctor can refuse to accept anyone as a patient except in an emergency and a patient can change doctors at will, so the principle of free choice and the proper relation of doctor and patient are retained.

The Act when first passed produced a storm of protest and rightly so, for the medical men were not consulted as to its provisions and they had little say in its administration in its medical aspects. Gradually, by threats and persuasion, the profession has taken on more and more medical control and the Ministry of Health is much more willing to listen to suggestions than formerly. I was told in England this past summer that a scheme for the proper payment of hospitalization is being considered and that the question of a more adequate return to the doctor for services rendered is under advisement.

In a paper such as this it is impossible to go into much detail. I can assure you that the system as it operates in Great Britain is most complicated, and probably not adapted to conditions here. Take for instance their administration of cash benefits. When the act was passed, it was decided to make use of the already existing Benefit Societies, or at least those of them that were sound, and willing to be taken over as part of the scheme. These societies that continue to exist are spoken of as "approved societies." About a third of the total contributions is turned over to the approved societies to be doled out as cash to the insured persons unable to work. A weak link in the chain lies in the fact that a certificate of disability must be issued by the panel doctor in attendance, and he, being only human, is perhaps too prone at times to let his sympathy outweigh his sound judgment in declaring his patient unfit for work. At any rate, many of the differences of opinion that arise do arise right there and the panel doctors as a class would like to be relieved of this part of their job. A patient, once given a certificate of disability, is allowed, after the fourth day, 15 shillings a week if a man; 12 shillings if an unmarried female; and only 10 shillings if married.

This cash benefit continues for 26 weeks. If at the end of that time, the patient is not able to resume his occupation, he goes on to the weekly disablement benefit which amounts to just half the disability benefit. This disablement benefit continues until recovery, death, or until the age of 65 when the patient is automatically transferred to the old age pension. So much for sickness insurance in Great Britain. I realize fully that my presentation is woefully lacking in many particulars, but what I have said gives a rough outline of the National Insurance Act as in force there.

In Denmark, before 1892 when a nationally organized system of sickness insurance came into effect, about 100,000 of the population were members of privately organized benefit societies. These are still recognized and aided by the State, provided they subscribe to certain regulations. The system of insurance as originally established in 1892 was entirely voluntary. In 1931 nearly 50% of the entire adult population were members of sickness insurance societies. No merely voluntary insurance scheme had worked so well in any other country. Membership was given to persons of limited income, but this limit varied in different localities, as, for instance, in the rural districts where the limit was much lower than in Copenhagen. Wives were not insured because of their husband's membership but dependent children under 15 years of age were. Contributions that insured persons made varied from year to year and even in different places. In 1931 the average contribution was about $5.12 per year. The employers made no contributions. The State, however, contributed about one-fourth of the total amount.

In Denmark, it is enough to say that medical benefit is ample and includes not only medical care, but maternity benefit, hospitalization and the care of specialists. Cash benefits, on the other hand, are very small. The legal minimum is from 11 to 13 cents a day with a maximum of $1.61. Twenty-six weeks, in any one year, is the limit. Cash benefits also include three-fourths of the cost of medicines. Outside Copenhagen, all doctors in good standing who express their willingness may take care of insured persons. There the insured have free choice of physician. In Copenhagen, on the contrary, the physicians are definitely engaged by the Insurance Companies but are paid in the same way as physicians in other districts, viz., according to a definite fee schedule or at so much per year for each insured person on their lists.

In Denmark, nearly all physicians except the specialists engage in insurance practice. There has been no united opposition to the scheme on the part of the organized medical profession and since this includes all but a dozen of the Danish doctors, it is apparent that the medical profession there is satisfied with the law as it stands.

In October 1933, certain changes were made in the Danish Sickness Insurance Act that changed it from a purely voluntary one to what is in substance compulsory. Now every Danish citizen, regardless of income, is eligible to enter a fund, and every citizen must register with one or he must pay contributions to a so-called "continuation fund" which makes him eligible to enter an insurance fund if his means fall below the statutory limits. Contributions paid by members of the continuation funds are small—only $0.54 a year until they reach the age of 26, and after that $0.67. It is not necessary to go into detail regarding the penalties attached to failure to comply with the legal requirements for registering. Enough to say that 90% of the population over 15 years of age carries sickness insurance. In addition there is a complete system of invalidity insurance and old age pensions.

Whether one approves of sickness insurance or not, there are several perfectly evident advantages that must be acknowledged. In the first place, a large class of the population, in England amounting to 16,000,000 persons, are provided with much more competent medical attention than they ever received before and the medical attention so received is paid for. Through this proper medical attention, the general level of national health is certainly raised and, lastly, a great impetus has been given to preventive medicine by the close contact of the insurance doctor with the class where prevention is most necessary.

In closing, I wish to point out that Health Insurance is not socialized medicine. It is merely a pooling of funds, paid by workers or by workers and their employers, to be paid back in medical and cash benefits in time of sickness. It is operated by private practitioners. It preserves the right of the patient to choose his own doctor and the right of the doctor to accept or reject the patients applying for treatment. It gives the large class of low wage earners a sense of security in illness they never have had before and, lastly, but by no means least from the point of view of the medical profession, it is most heartily approved by the large majority of the practitioners in the two nations whose insurance acts I have tried to describe.

THE RHODE ISLAND MEDICAL JOURNAL



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OUR EDUCATIONAL POLICY — A CRITIQUE

A recent venture of the Rhode Island Medical Society has been the promotion of a series of popular health talks.

Although this particular phase of our educational policy may be of recent origin, the initial attempt to foster a better understanding of health matters was made by the Society at least a quarter century ago. At that time it was generally agreed that the Society should appoint a committee to formulate a program of public education. The available records contain but meagre information concerning the objectives and accomplishments of the committee during these early years.

In 1926, the committee decided to institute a more intensive program of health propaganda. For this purpose the increasingly popular radio was employed and a series of health lectures was broadcast throughout the State. Each lecture was briefly presented and adhering to the policy of the Society the speaker always remained unidentified. The value of the radio program was debatable, particularly when it became apparent that the time allowed for the broadcast was extremely brief, the hour of presentation always unsatisfactory, and the personal appeal of the speaker entirely lacking.

The committee of 1935, after considerable deliberation, decided to dispense with the radio program. Instead, a series of informal Sunday afternoon health talks was proposed. Reputable physicians were requested to speak and the lecture was broadcast. The advance publicity consisted of a placard display and a newspaper advertisement which announced the subject to be discussed and the name of the speaker. In spite of this apparent breach of "ethics" the identification of the speaker met with little condemnation.

Although the attendance during the first series of lectures was small, an appreciable degree of enthusiasm was apparent. It was decided to continue the "experiment." The response of the public during the 1936 series was most satisfactory. The lectures were becoming a success.

The greatly increased attendance and general interest in the project were largely due to more liberal publicity. The *Providence Journal* and *Evening Bulletin* generously published advance notices of the meetings, abstracted the lectures, and displayed the speaker's photograph. The committee considered the use of photographs solely for the purpose of attracting attention to the meetings and not to advertise the individual speakers.

There can be no doubt as to the merit of the plan for it has been estimated that the lectures have been attended by approximately 2500 persons. To this must be added the inestimable numbers reached through the press and radio.

There is an unquestionable public demand for informal meetings of this type. It would be well for each county society to establish its own committee on education and individually sponsor its program of health education. The Providence meetings have attracted few, if any, persons from neighboring cities and towns. Local physicians have been chiefly selected for speakers simply because it is quite impossible for a committee of three to contact all that are eligible. If these are to be considered disadvantages the present system might well be changed.

As a result of the successful efforts of the Society to promulgate health interest, a number of lay organizations and "cult" societies are now sponsoring health talks. There is an element of danger in this trend as it may well lead to the publicizing of the individual. Hence it may be assumed that such pro-

grams should be instigated only upon the authority and approval of representative medical societies.

Without properly directed publicity there can be little educational propaganda. But there is a nicety of balance that must be maintained if we are not to defeat its very purpose.

OUR LIBRARY

The Rhode Island Medical Society owns a valuable collection of books, stored in fireproof stacks and well catalogued. The collection is more remarkable in that it has been made with very little help from the treasury of the society. Books have been secured by gift and by exchange. The Providence Medical Association, beside its regular donation to the State Society, annually appropriates considerable sums for subscription to periodicals and for binding books in the library. The RHODE ISLAND MEDICAL JOURNAL provides magazines from its extensive list of exchanges. Those who review new publications for the JOURNAL uniformly donate the volumes reviewed. Unique in this library are the Davenport Collection of non-medical works by physicians, Dr. Frank E. Peckham's orthopedic collection, and the volumes on public health collected by Dr. Charles V. Chapin. More recent additions are 289 volumes from the library of the late Dr. John W. Keefe, a complete set of the Transactions of the Rhode Island Medical Society given by Dr. Stephen A. Welch, and a copy of "The Edwin Smith Surgical Papyrus," which was purchased for the library by Dr. Roland Hammond. This work was briefly described in an editorial in the January JOURNAL. It may also be consulted at the Medical Library. We have here mentioned examples of generous interest in the library which might well be imitated by other members of the Society.

MEDICAL FACTIONS

It is said that it is impossible to get a group of physicians together unless there is a good collation awaiting them. Often when they do meet they spend a good deal of time wrangling about petty things. Then when the food is served, they become better natured — so much so that one wonders if it wouldn't be advisable to serve the food first. Some time ago the writer read a paper in a city which perhaps has 1,000 physicians. There were about thirty present at the dinner and while the paper was being read there were about seventy-five present. The president later pointed out that only his friends came and when the next man entered office, his group would drop out and another clique enter the picture. Medical societies, especially smaller ones, are divided into cliques and spend valuable time wrangling about details that a child of 16 would work up. Often the wrangling goes so far that the speaker may have to cut out an address he had prepared and only touch the high spots.

There is so much to gain when physicians get together. Problems are taken up and solved. One should be willing to listen to a paper even if it is read by someone not in his own clique. Cliques may cause more damage to the profession than we realize. Look over these county societies which devote so much time to petty things and you will find that no one in those localities has ever made a single advance in medical science. And they never will as long as their minds are concentrated on their own petty jealousies. Many of these smaller societies need a broader view towards their obligations to others. And those obligations are that we must at all times try to advance medical knowledge. After attending some of these meetings one feels that he could have profited more by remaining at home, reading a good medical journal.

PAWTUCKET MEDICAL ASSOCIATION

April Meeting

The regular meeting of the Pawtucket Medical Association was held at the Nurses' Auditorium of the Memorial Hospital on April 15, 1937, and was called to order by the President, Dr. E. A. Cormier. After the reading of the records of the previous meeting, the President, out of respect for the memory of the late Dr. Harry A. Manchester, whose funeral service was held on this day, requested all present to stand in silence for one minute and then immediately entertained a motion for adjournment. Dr. Manchester was a Past President and Vice President of the Pawtucket Medical Association. He died on April 12. His funeral was attended on April 15.

Respectfully submitted,

THAD. A. KROLICKI, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the April Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Peter Pineo Chase, on Monday, April 5, 1937, at 8:35 P. M. The minutes of the last meeting were read and accepted.

The Secretary read a letter from Dr. N. J. Strauss announcing the Clinical Congress of the Connecticut State Medical Society to be held on September 21, 22 and 23, 1937.

The President read a letter from the Providence District Nursing Association in which it was suggested that he appoint a member of the Providence Medical Association to serve on the Board of Governors of the District Nursing Association as a representative of the Providence Medical Association. It was voted that the President be empowered to appoint a representative.

Their applications having been approved by the Standing Committee, the following were elected to membership:

Frederick Charles Hanson
Harold Wesley Williams

Dr. Edward F. Burke read an obituary of the late Dr. J. Edward McCabe. It was voted to spread this on the records and to send a copy to the family.

The President read a letter from the Bureau of the Handicapped in which it was suggested that he appoint an Advisory Committee to act with and advise the Bureau of the Handicapped. It was voted that the President be empowered to appoint such a committee.

The President announced that he had appointed Dr. William P. Davis, Treasurer of the Providence Medical Association, to complete the unexpired term of the late Dr. Charles F. Deacon.

The President then reminded the Association that Dr. Charles H. Leonard had been elected President of the Providence Medical Association 48 years ago, at which time there were but 25 members and annual expenses of $300.00. The President announced that he would write a letter to Dr. Leonard extending to him the greetings of the Association. Dr. John M. Peters stated that he was present at the meeting in which Dr. Leonard was elected President, and he gave interesting and amusing reminiscences of that meeting.

The first paper of the evening was read by Dr. Cecil C. Dustin and was entitled "Brucella Infections in Man." The paper was discussed by Drs. Wellman, Bates, and Chafee.

Dr. Joseph L. Belliotti read an obituary of the late Dr. Frank J. Jones, and Dr. George S. Mathews read an obituary of the late Dr. Charles F. Deacon. It was voted that these be spread on the records and copies be sent to the families.

The second paper of the evening was read by Dr. Herman Pitts and was entitled "Review of Sickness Insurance in Foreign Countries." The paper was discussed by Drs. Kiene, Wells and George Mathews.

The meeting adjourned at 10 P. M. Attendance 102. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary*

OBITUARY

DR. JOHN GEORGE O'MEARA

Dr. John George O'Meara passed away on November 22, 1936, at St. Joseph's Hospital, after a long illness. He was born in Valley Falls, Rhode Island, on July 4, 1868, and educated in the public schools of that town, later attending Bryant and Stratton Business College, Philips Exeter Academy and the Collegiate Department of Ottawa University. He studied medicine at the University of Pennsylvania Medical School, receiving his degree in 1899. After serving an interneship at St. Mary's Hospital, Philadelphia, he began private practice in this city in 1901. He was married to Dr. Catherine Elizabeth McGovern in 1905. Dr. O'Meara always maintained a lively interest in civic affairs—elected and served as a member of the Rhode Island House of Representatives from 1914 to 1918. He was a member of St. Joseph's and the Homeopathic Hospitals, the American Medical and Providence Medical Associations, and the Rhode Island and Massachusetts State Medical Societies. Dr. O'Meara possessed a genial disposition and was a truly ethical physician, carrying out to the fullest extent the precepts of its teachings. He was respected by all and loved by many—thoughtful and devout. He is survived by his wife, Dr. C. Elizabeth O'Meara, and three daughters, Mrs. George S. Wattendorf of Newton, Massachusetts, and the Misses Catherine and Ellen O'Meara of this city.

CHARLES H. GANNON, M.D.
RICHARD F. MCCOART, M.D.

THE PROVIDENCE TUBERCULOSIS LEAGUE, The Lakeside Home and Mary Murray Preventorium 1936 Annual Report

JOHN I. PINCKNEY, M.D.
100 NORTH MAIN STREET, PROVIDENCE, R. I.

In tuberculosis work we are confronted with an ever changing picture. Appraisal of our activity is a continued obligation. Periodic surveys by experts outside our own ranks are highly desirable, provided the work be examined against the background of the local health picture. During the past six years we have had three such surveys and much valuable information has been derived therefrom. Some of the recommendations have been idealistic; others, entirely practical, and wherever they have fitted into our local picture, an earnest endeavor has been made to carry them out, but the factors are continually changing. Yearly appraisals are therefore necessary if we are to make our maximum contribution to the community in its plan for the ultimate control of tuberculosis. Since we cannot afford a well trained statistician to point out our short-comings, experience has shown that the next best means of appraising our work is by carefully filling in each year the American Public Health Appraisal Form. The answers obtained are our guide posts in shaping our program for the coming year.

While the general death rate has declined through succeeding years, the rate for the specific age group from fifteen to twenty-five, particularly among females, has remained relatively high. In Providence in 1928 this group accounted for 41 or 20% of the total deaths from tuberculosis. During the eight years that have elapsed an effort has been made to reach as many as possible in this age group with the result that the death rate has been reduced by 59%, and because of the increased numbers handled more new cases have been found, 41% of whom this year were in the early stages of the disease. These two facts argue well for a still lower rate next year.

The deaths in Providence this year, when compared with those of 1928, show that the peak of the death rate has shifted from the twenty to twenty-four year group in 1928 to the forty-five to forty-nine year group this year. Other obvious lines of attack are clearly pointed out in the death returns of the past few years. Among occupations showing a high incidence in tuberculosis in males are manufacturing and mechanical industries and domestic service and among females, in domestic service and trades. Among the racial groups, Irish and natives of the Cape Verde Islands present their problem. Ways and means must be found to reach still larger numbers in these groups.

For a number of years we have tried to interest employers in having a higher percentage of their people examined, but up to the present time the employer could not see any real advantage to himself in taking on this added responsibility. The employee was also reluctant, being fearful of losing his job. With passage of the Security Act embracing industrial hygiene, under which there are listed thirty-eight occupational diseases for which the employer may become liable, it is now not only desirable, but necessary for his own protection, to have pre-employment examinations including an X-Ray of all applicants.

The State Board of Health has recently issued a new and excellent ordinance which provides for employees handling food and beverages a designating button, if their yearly compulsory examination includes a Wasserman and an X-Ray of the chest. These two new features should uncover many heretofore unsuspected cases of tuberculosis. It is our hope that we may participate in this work to a considerable extent, as it is among these groups that the highest death rate occurs and the incidence of the disease is at its peak.

The fundamental principle underlying the control of tuberculosis is the finding of cases and finding them early: from the patient's standpoint early discovery, when in most instances he may readily be restored to health at a minimum of expense and time lost; from the public's standpoint, before there has been a chance for the sufferer to become a spreader of infection to others, when the cost of restoring him to health is great and the result uncertain.

When tuberculosis is finally mastered, the private physician rather than any agency or group of agencies will be the chief factor in sealing its doom. In developing the work here in Providence, I have kept this thought continually in mind, although in the early years it was most discouraging to find that less than five-tenths of one per cent of the new cases of tuberculosis found in the clinic came through the private physician. This year it is most gratifying to find that out of the 277 new pulmonary cases found in the clinic, private physicians accounted for 169, or 61%.

The public is not yet alive to the fact that tuberculosis can lurk in a strong young body for months without a telltale symptom. Quietly the disease spreads and the first warning one may have of its presence is a hemorrhage from the lung. It may only hint at its presence by a cough that hangs on, by loss of weight, indigestion, or unexplained fatigue; but by this time serious damage has been done. Few people ever dream of consulting their physician until they are ill. It is not surprising to find that in over 80% of patients referred by the physicians the disease was moderately or far advanced at the time of their first visit.

Since the physician is the most fruitful source of new cases reported he should be encouraged in seeking cases among contacts and other susceptible groups by tuberculin skin testing and X-Raying of the positive reactor. Much of this service has not been done because the service could not be paid for; yet if carried out to any considerable extent would result in many early cases being found before they become a menace to others. It would be a sound economic policy to reimburse the physician for this work from public funds.

The attendance at the tuberculosis clinic by old and new patients for the year totalled 21,883 compared with 19,998 in 1935, an increase of 1,885 or 9.5%. During the year 4,786 new patients were admitted to the clinic and 4,012 readmitted, totalling 8,798 persons, 1,035 or 13% more than last year. This number represents one in every twenty-nine individuals in Providence. The ratio of clinic visits to individuals seen, 2.5, is below the standard of 3 visits per individual set in the American Public Health Association Appraisal Form, but the character of our work, handling as we do large numbers through physicians, department of public aid, schools, and colleges, many of whom are seen only once, pull our average down. Among the 8,798 individuals seen, 2,643 gave a history of exposure to tuberculosis. 4,452 were given the tuberculin skin test and of this number 34% reacted positively. Separating the clinics from the school children tested, who represent a fair cross-section of the city, the percentage of those who reacted this year, 26.5, is 4.2% higher than among similar groups tested in 1935. This increase probably reflects the sharp rise in the death rate during 1935. During this year 5,952 X-Rays were taken as against 5,182 last year, or an increase of 770. Among the high school students a higher percentage showed evidence of calcium deposits either in the lung or in the glands at the root of the lungs, than from any similar group.

This increase in the number infected makes it imperative that we develop a better follow-up system for these young people if we would prevent the more serious pulmonary form of the disease ten or fifteen years hence. The freshman class at Brown was X-Rayed again this year. A different practice was employed at Pembroke, the students being first tuberculin tested and only the positive reactors X-Rayed.

In the pneumothorax clinic at the Charles V. Chapin Hospital 2,376 refills were given. Dr. Zambarano of our staff, who has charge of this clinic, has been voluntarily assisted by Dr. J. Murray Beardsley, Dr. Harvey Wellman, Dr. John Ham, Dr. John Capobianco, Dr. Frank A. Merlino, and the resident staff. Medical ethics does not permit these men and hundreds of others who serve the community daily in our hospitals and clinics without compensation, to advertise their many good deeds. Some of us fully appreciate this volunteer work but the public as a whole takes it as a matter of course.

The number of deaths from all forms of tuberculosis in the city of Providence in 1936 was 114, including 9 non-residents. In addition there were 47 Providence residents who died elsewhere, making our corrected death rate for the year 60 per 100,000 as against 63.5 per 100,000 in 1935.

At Lakeside, operating on a curtailed budget which limits the average number of children that can be cared for to 35, the daily per capita cost for the year, including maintenance and all repairs and improvements, was $1.43. The 1935 average cost of all preventoria in the country was $1.50 per day. Because of the limited number of children who can be cared for, greater care has been exercised in their selection that those most in need of this type of treatment might be provided for. 134 children were admitted during the year and 125 were discharged. The largest daily attendance was 53, the smallest 26 and the average 35.5. The average length of stay was 80.5 days. The total number of days' care given was 12,951.

In the dental department conducted by Dr. Walter C. Robertson, who visits Lakeside once a week, an effort has been made to clean, treat, fill and extract teeth of all those children in need of dental care.

It has been most interesting to watch during the past two years the effect of a low starch diet. While

the average gain in weight has not been as great as formerly, most of the children have held their weight after discharge and many have continued to gain without interruption, whereas with a high starch diet this was the exception rather than the rule.

The Lakeside Committee, under the chairmanship of Mr. William J. Reed, has been active throughout the year. It was our privilege during July and August to provide a building, formerly used for summer outing work, to house fifty children under the care of the Rhode Island Infantile Paralysis Foundation and to furnish meals at cost from our kitchen. That the plan worked out admirably is evidenced by the fact that both organizations are willing and anxious to repeat again this year. In spite of the 1936 survey report condemning the practice of carrying on different types of work at Lakeside, this experience furnishes one more proof of our contention that it is possible to do so in a satisfactory manner without conflict.

RECENT EVENTS

Dr. Edgar B. Smith, for many years the highly esteemed Dean of the Rhode Island medical profession, died in his eighty-fourth year while on a visit to Orlando, Florida. On the evening of April 9 he retired in his usual cheerful spirits and quietly passed away as he slept. The funeral was held at the First Congregational Church in Providence at noon on April 14. The service was conducted by a lifelong friend, the Reverend Augustus M. Lord. The bearers were Drs. Frank T. Fulton, Murray S. Danforth, Halsey DeWolf, Albert H. Miller, Herman C. Pitts and George L. Shattuck. The ushers were Drs. Emery M. Porter, Robert R. Baldridge, Albert A. Barrows, Alex. M. Burgess, Adolph W. Eckstein, Nathaniel H. Gifford, Guy W. Wells, and Mr. Wallace D. Kenyon. Interment was at the family lot in North Burial Ground.

March 28.—Although it was a pleasant Easter afternoon, a large audience attended the final popular lecture at the auditorium of the Medical Library. Dr. David R. Brodsky presented the modern accomplishment of painless childbirth through the use of barbituric acid derivatives. Dr. Alfred L. Potter described the conduct of maternity cases in Providence. He gave well merited praise to the work at the Providence Lying-In Hospital, where the mortality rate is less than half that in the community as a whole.

April 8.—The regular monthly meeting of the Staff Association of St. Joseph's Hospital was held in the Nurses' Auditorium on Peace Street at 12 noon. Dr. Torr W. Harmer of the Department of Surgery of the Massachusetts General Hospital read a paper on "Infections, Injuries, Reconstruction of the Hand." Collation was served at 1 P. M.

April 9.—Dr. George W. Waterman entertained the William W. Keen Medical Club. Dr. Francis B. Sargent read a paper on "Treatment of Accessory Sinusitis."

April 13.—Dr. Charles W. Higgins entertained the Amos Throop Medical Club. Dr. John S. Dziob, Resident at the Jane Brown Memorial, read a paper on "Diabetes." On a historical background he sketched the remarkable advances which have been made in treatment of the disease.

April 16.—At the regular monthly meeting of the Friday Night Medical Club, Dr. Frank T. Fulton read a carefully prepared paper on "Digitalis." Dr. G. Alder Blumer dwelt on the high privilege of intimate association with the late Dr. Edgar B. Smith, which the members of the club had enjoyed through many years. By his death the Friday Night Club and the community suffer an irreparable loss.

April 20.—At the regular monthly meeting of the General Staff of the Homeopathic Hospital of Rhode Island, at 12:30 P. M., Dr. Wesley Spink gave the fifth of the present series of lectures. His subject was "Arthritis." Luncheon followed.

April 27.—At the meeting of the Malpighi Medical Club Dr. Francesco Ronchese gave an interesting lantern demonstration of "Some Common Skin Conditions."

April 28.—At the regular monthly meeting of the Jacobi Medical Club, held at the Miriam Hospital Annex, Dr. Sidney H. Weiner of the Boston Children's Hospital spoke on "Allergy in Children."

April 29.—The Rhode Island Medico-Legal Society held a regular quarterly meeting at the Medical Library Building, at 5 P. M. Sergeant Charles R. Blake, Scientific Investigator, Division of Rhode Island State Police, spoke on the subject "New Processes in Acquiring Scientific Evidence." Following adjournment, a light supper was served. This Society merits an increased membership and a larger attendance at its sessions. The President is Sigmund W. Fischer, Jr., Esq.; the Secretary, Dr. Jacob S. Kelley.

Rhode Island Hospital

CALENDAR FOR MAY, 1937

Tuesday, May 4
7:30 P. M. Internes' Pathologic Conference
Thursday, May 6
8:30 P. M. Gynecological Staff Meeting
Friday, May 7
7:30 P. M. Urological Staff Meeting
8:30 P. M. Surgical Staff Meeting.
Tuesday, May 11
12:00 Noon Clinical-Pathologic Conference
Friday, May 14
11:00 A. M. Pediatric Grand Rounds
Tuesday, May 18
7:30 P. M. Internes' Pathologic Conference
Tuesday, May 25
12:00 Noon Clinical-Pathologic Conference
Friday, May 28
11:00 A. M. Pediatric Grand Rounds
Mondays and Tuesdays, 10:30 A. M.
Surgical Grand Rounds and Round Table; first and second divisions alternate
Wednesdays
10:00 A. M. Tumor Clinic
12:00 Noon Skin Clinic (Peters House)
Thursdays
9:00 A. M. Orthopedic Grand Rounds
12:00 Noon Thoracic Clinic (Basal Metabolism Room)
Fridays
11:00 A. M. Fracture Rounds
11:30 A. M. Heart Conference.
Saturdays
10:00 A. M. Medical Conference (Peters House)

Dr. Fred Woodward Lewis of Yale University, 1933, and Tufts Medical, 1937, started internship at the Rhode Island Hospital April 15th, 1937. Dr. Lewis' home is in Stoneham, Mass.

The marriage of Dr. Ira H. Noyes to Miss Alice Bowlby took place on April 3rd, 1937, at Wickford, R. I. Mrs. Noyes is a graduate of the Rhode Island Hospital School for Nurses. Dr. and Mrs. Noyes are living at 242 President Avenue.

Dr. Frederick A. Webster, who has been Night Superintendent at the Rhode Island Hospital from October, 1936, to April 1st, 1937, was married April 3rd, 1937, to Miss Charlotte Straw Howard. Mrs. Webster is a graduate of Vassar College and Katherine Gibbs School in Boston, Mass. Dr. and Mrs. Webster have taken up residence at 298 Pleasant Street, Rumford, R. I. Previous to becoming Night Superintendent, Dr. Webster was on the teaching staff at Tufts Medical and at the same time was associated with the Boston Dispensory.

Dr. Luther McDougal, son of Dr. McDougal of Boonville, Mississippi, started internship at the Lying-In Hospital April 1st, 1937. Dr. McDougal interned at the R. I. H. from March 1935 to March 1937. He is a graduate of the University of Mississippi and Vanderbilt Medical College, Nashville, Tenn. Previous to coming to the R. I. H., Dr. McDougal interned at Vanderbilt Hospital in Nashville, and at the Babies' Hospital in New York. While an intern at the R. I. H., Dr. McDougal was married to Miss Dorothy Atkinson, a graduate of the R. I. H. School for Nurses. A daughter was born to them during his term of internship.

Dr. Lee George Sannella, son of Rev. Frank Sannella, Brown University 1930, and Boston University Medical School 1934, whose internship of two years terminated at the R. I. H. April 1st, 1937, became Night Superintendent at the R. I. H. on that date.

Dr. Charles Hanson has opened an office at 162 Angell Street for the practice of eye, ear, nose and throat work.

Dr. Lawrence Martineau of the R. I. H. X-ray Department and Miss Renier Fisher were married the morning of April 15th at Attleboro, Mass., and have taken up residence at 576 Willet Avenue, East Providence. Mrs. Martineau is a graduate of the R. I. H. School for Nurses.

Woonsocket Hospital

The regular monthly meeting of the Staff of the Woonsocket Hospital was held on March 8. General recommendations were made for improvement of both the professional and clinical work of the hospital. Drs. Walter C. Rocheleau and Henri E. Gauthier discussed extra-uterine pregnancy from the diagnostic point of view and illustrated their conception with a case history A short analysis of the differential points in the diagnosis of ruptured appendix with general peritonitis, simulating pneumonia, was presented by Dr. Gauthier.

The monthly clinical conference was held at the Woonsocket Hospital on March 22, with Dr. Thomas J. Lalor presiding. Dr. Auray Fontaine

presented a case of diabetes with complicating psychoneurosis. The discussion was opened by Dr. Joseph W. Reilly. The second case, one of sarcoma of the periosteum at the upper end of the tibia, was presented by Dr. Cyril Israel. The insidious onset was stressed in the discussion by Drs. Francis J. King and Victor H. Monti.

Minutes of the Caduceus Club

The monthly meeting of the Caduceus Club was held at the To Kalon Club on April 12. The meeting was called to order by President Mara. The recommendations concerning the School Health Department, tabled from the last meeting, were considered for final action. There was considerable discussion of the ten original points by Drs. Vandale, Sprague, Krolicki, Trainor and Henry, following which it was voted that the following nine recommendations be accepted:

(1) A recognized standard course in first aid to be taken by selected school personnel.

(2) Elimination of group pre-school examinations in favor of a complete physical examination by the family physician, but modified to permit the examination of children without fee in the event parents are unable to pay.

(3) Examination of vision and hearing to be done according to the State Law.

(4) Elimination of treatment of pupils by school teachers except in emergencies requiring first aid.

(5) Cases of illness or injury among pupils to be handled by family physicians.

(6) Evolution of some method of checking absentees to determine whether they are suffering from contagious disease.

(7) Placing of school nurses under the direction of school physicians, the nurses to act on order of the physicians and not on order of the school officials.

(8) Full authority for school physicians to decide whether or not a child should be accepted for the open air school.

(9) Standard first aid equipment for each school, such equipment to be used under the supervision of the school physicians.

On motion by Dr. Krolicki, it was voted that these recommendations be accepted and that a copy of the same be forwarded to the Superintendent of Health, to be released through his office.

It was voted that Drs. J. H. Gordon and M. W. Paydos be elected to regular membership in the club.

Following a collation, the meeting was adjourned.

Respectfully submitted,

George B. McClellan, M.D.,
Secretary.

The third annual meeting of the American Neisserian Medical Society will be held on June 8, in The Senator, Atlantic City. The program will consist of papers and discussions of the various phases of the management and control of gonorrhea. All who are interested are cordially invited to be present. The meeting will begin promptly at 10:00 A. M. and will continue through the day.

The American Medical Golfing Association will hold its twenty-third annual tournament at Seaview Country Club, Atlantic City, N. J., on Monday, June 7. Thirty-six holes of golf will be played in competition for seventy trophies and prizes in nine events. All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A. M. G. A. Write the Executive Secretary, Bill Burns, 2020 Olds Tower, Lansing, Michigan, for an application blank.

BOOK REVIEW

Materia Medica, Toxicology and Pharmacognosy. By William Mansfield, A.M., Phar.D., Dean and Professor of Materia Medica and Toxicology, Union University, Albany College of Pharmacy, Albany, N. Y. pp. 707 with 202 illustrations. Cloth, $6.75. St. Louis, The C. V. Mosby Company, 1937.

This book is remarkable for the complete and detailed descriptions of each individual drug in the crude form, with accompanying full page illustrations, which together occupy about 500 of the book's 700 pages. As a reference book for those interested in the origin of a particular drug, and for pharmacists, this section should prove of distinct value, although the lack of any but the most general information regarding the therapeutic action of these drugs will prevent its wider use by physicians. Probably of more practical value to them is the section on toxicology, occupying a little over 100 pages, which gives in condensed form the symptoms and treatment of all types of poisoning. Perhaps due to the limited space available descriptions of the morbid anatomy and physiology are not included, and no mention is made of some of the newer developments in this field—such as the dangers of "de-leading" in children, or the treatment of mercury poisoning with sodium formaldehyde sulphoxalate. The final section is made up of a table of dosages. The book should find its greatest usefulness as a text book for students of pharmacy.

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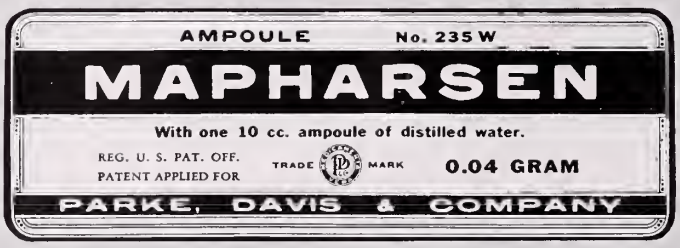
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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
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Spontaneous Subarachnoid Hemorrhage, by Dr. Charles A. McDonald and Milton Korb

Diabetes among the Moderns, by Dr. John S. Dziob

Strongyloides Stercoralis, by Dr. Laurence A. Senseman

Officers and Fellows of Newport and Kent County Medical Societies on Page XII

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Beriberi-preventing diets of Chinese coolies and natives of Java have been estimated to contain 200 International units of vitamin B_1 (1). Practical use is made of knowledge such as this in the Philippines, where the Bureau of Science, in a successful effort to combat beriberi, dispenses tikitiki (vitamin B_1 concentrate from rice polishings) containing approximately 200 International units of vitamin B_1 per daily dose.

It is generally agreed that the absolute requirement for this factor may be variable, depending upon such factors as size and caloric intake of the individual. However, equations have been derived which take into consideration some of these variables and are useful in estimating the adult vitamin B_1 requirement (2).

Application of these equations indicate that approximately 225 International units of vitamin B_1 per day are required for the average American adult. The average daily infant requirement has been estimated to be 50 International units, increasing to 200 units at the time of adolescence (1). The League of Nations Technical Commission recommends a daily intake of over 150 International units for pregnant and lactating women (3).

While it may be possible to estimate the daily intake of vitamin B_1 which will prevent clinical beriberi, it is not yet possible to state the minimum amount of the vitamin which, when imposed on an otherwise adequate diet, will promote optimum nutrition. There is increasing belief that some of the vague disorders, noted clinically, may be in reality manifestations of suboptimal vitamin B_1 intake (4).

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(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 70
(2) The Vitamin B Requirements of Man. G. R. Cowgill Yale University Press. New Haven. 1935
(3) 1936. Nutr. Abst. and Rev. 5, 855
(4) a. 1936. J. Am. Med. Assn. 106, 261
b. 1935. Ibid. 105, 1580
(5) a. 1932. Ind. Eng. Chem. 24, 457
b. 1932. J. Nutrition 5, 307
c. 1934. Ibid. 8, 449
d. 1935. Ibid. 11, 383
(6) 1934. U.S. Pub. Health Rpts. 49, 754

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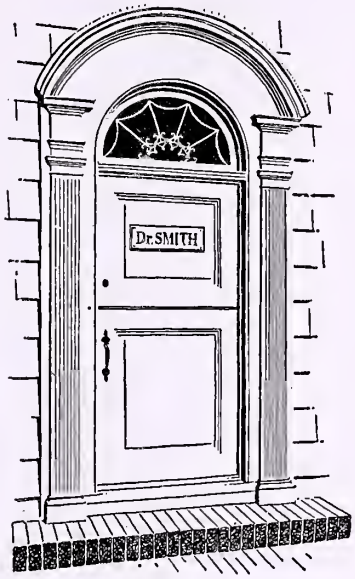
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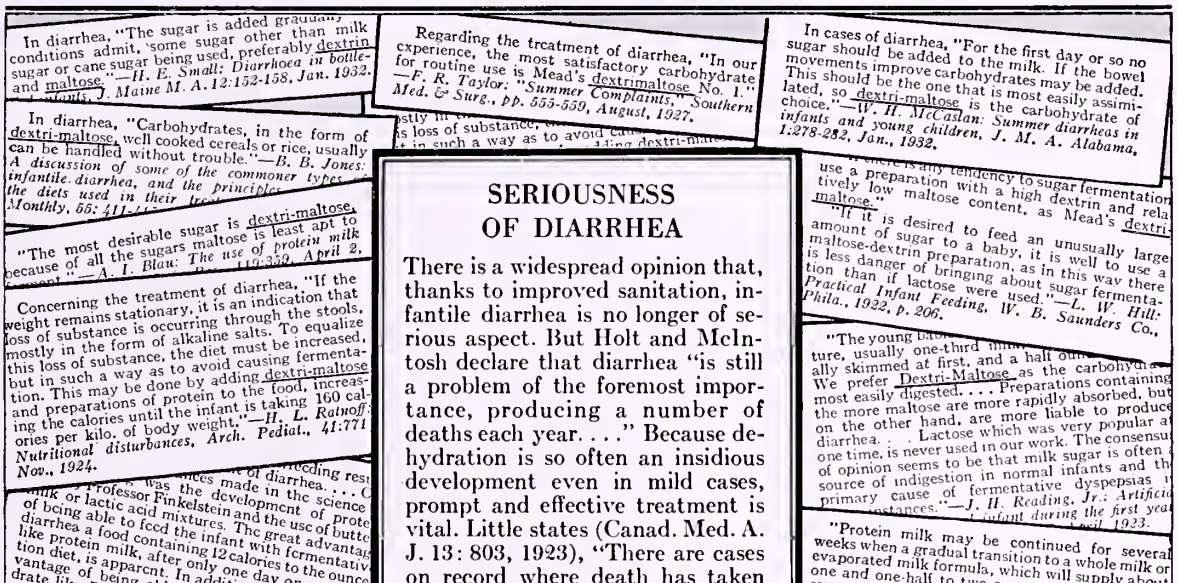
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JOHN S. DZIOB, M.D.

RESIDENT PHYSICIAN, JANE BROWN MEMORIAL HOSPITAL, PROVIDENCE

Diabetes, unlike Syphilis, extends back to the dawn of civilization. Reference to it can be found in the famous Ebers Papyrus; hence the ravages of the disease must have been known to the ancient dwellers at the mouth of the Nile. The name Diabetes[1] was applied by the authors of antiquity to a disease which they characterized either by one or all of the familiar triad of symptoms; loss of weight, excessive urination, and tremendous thirst. Aretaeus,[2] the Cappadocian, more than seventeen hundred years ago, wrote of this illness: "the flesh melted into urine and the thirst was excessive." Sixteen hundred years later, in the seventeenth century, when diabetes was also known as the "Pissing Evil," Willis,[2] a contemporary of Sydenham, found by tasting it, that the urine of diabetics is sweet, "as if imbued with sugar or honey;" thus at once differentiating this disease from Diabetes Insipidus. Mathew Dabson, a pioneer in medical research, proved, in 1750, that the substance giving the sweetish taste is sugar.[2]

In the following century, 1889, Mering and Minkowski[2] extirpated the pancreas of a dog, to settle thereby an argument as to the fate of an animal subjected to such an operation. Minkowski noticed that flies clustered thickly on the urine of his depancreatized animals. His curiosity thus aroused, he found on investigation that there was sugar in the urine to the extent of five percent.; and that, moreover, all of his operated dogs thereafter died with the symptoms of diabetes. This was probably the greatest single contribution to the study of the disease and one of the most brilliant discoveries in medicine. In 1900, Eugene Opie,[2] then instructor in pathology at Johns Hopkins University, described for the first time, in the pancreas of diabetics, a hyaline degeneration of the Islands of Langerhans. It was Opie's discovery which led Sir Edward Sharpey-Schafer to postulate, in 1916, the theory that diabetes was due to the lack of a hypothetical internal secretion, normally elaborated by the Islands of Langerhans. To this he gave the name Insulin.

The problem of extracting the active principle of the Islands of Langerhans[1] was settled by Banting, a young Canadian orthopedic surgeon, who, fascinated by the challenge of finding a cure for an incurable disease, gave up his practice and went to work in Prof. MacLeod's laboratory in Toronto. He was assigned a second-year medical student, Charles H. Best, to assist him. In less than one year, these lucky workers triumphed where others for centuries had failed. The year following, in 1922, they successfully introduced insulin into medical practice.

One of the most interesting clinical signs in diabetes,[2] the characteristic air-hunger of severe acidosis, was first described, in 1874, by Adolf Kussmaul. It is now called after him, the Kussmaul type of respiration.

The last advance in diabetic therapy, coming just sixteen years after the discovery of insulin, is the development of Protamine insulin by Hagedorn. This advance, according to Joslin,[10] which promises to control the mild and moderately severe cases with a single dose of Protamine insulin combined with a diet but moderately restricted, ought to be recognized and named for its discoverer—"the Hagedorn Era."

Metabolism in Diabetes

Diabetes is a disease of carbohydrate metabolism. In it the tolerance of the individual for carbohydrates is to a varying degree less than normal; consequently, glucose[3] is not removed from the circulating blood and stored, as it ordinarily should be, in the liver and muscles in the form of glycogen, the latter being the animal, or so to speak, warehouse kind of glucose. Its level in the blood, therefore, rises over and above the renal threshold of one hundred and eighty mgms. percent., and is spilled into the urine, as the familiar glycosuria.

The carbohydrates[3] thus passing through the body unoxidized, there results a great loss of energy, for which the body tries to compensate by an utilization of its proteins and fats. The metabolism of the former (proteins) does not appear to

Read before the Amos Throop Medical Club, April 13, 1937.

be seriously disturbed, and so the carbohydrate portion of the protein molecule, in part, takes the place of the lost sugars. The danger, however, arises in the metabolism of the fats. Here the loss of sugar is vitally felt; because the complete combustion of fats demands a simultaneous oxidation of a definite quantity of glucose, the ratio necessary being recognized as one gram of glucose to two and a half grams of fatty acid, or approximately one gram of carbohydrate to three grams of fat. This is simply a modified reiteration of the hackneyed expression, "fats burn only in the flame of carbohydrates."

In consequence of the failure of oxidation of sugar, the fat metabolism proceeds to an incomplete extent; namely, to the formation of the ketone bodies; the obnoxious hydroxybutyric acid, diacetic acid, and acetone. These substances produce the acidosis that brings in its wake coma and death in untreated diabetes.

There are two simple tests available[12] for the detection of ketone bodies in the urine, and accordingly, by the same token, of the degree of acidosis in the body. The ferric chloride test for diacetic acid detects these substances only when they are present in quantities which indicate the imminence of coma. Patients showing the same, present medical emergencies and should be treated as such. The nitroprusside test for acetone detects these substances when they are present in but minute amounts. Hence patients with a negative ferric chloride test but a positive nitroprusside reaction are in no immediate danger, but they do harbor a grossly disordered metabolism.

All diabetics can utilize or tolerate some glucose. The degree of their inadequacy allows us for practical therapeutic purposes to classify them as mild, moderately severe, or severe cases; and consequently, it governs the ease or difficulty with which the derangement may be restored to a semblance of normal.

A mild diabetic[4] usually shows both glucose and acetone in the urine; a slightly elevated fasting blood sugar (from 150-250 mgs. percent.); but a normal alkali reserve figure (50-80 vol. percent.). A moderately severe diabetic[4] reveals sugar, acetone, and, in addition, diacetic acid in the urine; a moderately elevated fasting blood sugar (from 250-400 mgs. percent.); and a moderate degree of acidosis, i.e., an alkali reserve figure of 40 and over. A severe diabetic[4] differs from the others in the greater height of the fasting blood sugar (from 400-1200 mgs. percent.); and in the greater degree of acidosis, i.e., an alkali reserve figure from 40-30. Impending coma[4] is recognized to be present when the alkali reserve figure is below 30. Incipient or early diabetes,[4] on the other extreme, is present when the urine betrays occasional traces of sugar; the fasting blood, a slight elevation of its glucose (up to 150 mgs. percent.); and the dextrose tolerance test, a diabetic type of curve.

The metabolism of a diabetic may be judged to be functioning in a controlled manner[12] when the fasting blood sugar and alkali reserve figures are normal, when the urine is always free of acetone bodies, when the waste of glycosuria has been reduced to a minimum compatible with freedom from hypolycemic attacks; and clinically, when the patient enjoys a degree of health and energy adequate to the requirements of his activities. This aim can be achieved by the appropriate use of diet alone in mild cases, and of diet and insulin in the severer ones.

Factors Governing Carbohydrate Tolerance

It is readily realizable that deficient carbohydrate tolerance is really the crux of the problem of diabetes. Hence it becomes important to inquire into factors which modify this tolerance, for fortunately, it would appear that tolerance in a diabetic is an alterable condition. Insulin, as we all know, raises it; exercise appears to do the same, for the amount of insulin needed to control the patient in bed is much greater than that required when the patient becomes ambulatory. It is further known "that the susceptibility[12] of the body to the action of insulin varies at different times of the day, being least at breakfast, more marked in the evening, and most marked in the middle of the day." Finally, it is also well known that some diabetics, after they have been under control for several weeks or months, appear to recover some of the lost function of the pancreas, so that they may thereafter get along on diet alone, or on much smaller doses of insulin and a more liberal diet than was formerly feasible.

There are, however, factors which decrease the tolerance and thus aggravate the disease. Joslin stresses the fact that obesity predisposes to diabetes, and he finds that his patients do better if they are kept slightly underweight. Infection, etherization, or pregnancy may serve to plunge an otherwise

controlled diabetic into acidosis; and in these conditions it is found that much larger amounts of insulin are needed for effect, than would otherwise be necessary.

The thyroid, the pituitary,[11] the hypothalamus, and the basal ganglia would also appear to have some effect on carbohydrate tolerance. Thus in hyperthyroidism one gets a decreased tolerance, and consequently, an increased fasting blood sugar, which simulates that of a mild diabetes. When the pituitary gland[11] is removed in a depancreatized dog, the severity of the diabetes is thereby very much lessened. Removal, however, of the adrenal[11] does the same for the depancreatized cat. Hence there remains still much to be learned about this fascinating subject of carbohydrate tolerance.

Dietary Considerations

According to Joslin,[10] there are approximately five hundred thousand individuals with diabetes in the United States, although some of these may not know that they have the disease. Some three hundred thousand, or sixty percent., are mild cases; one hundred seventy-five thousand, or thirty-five percent., moderately severe; and only twenty-five thousand, or five percent., severe cases. The fact that the greatest percentage of the diabetics are in the mild and moderately severe groups makes the treatment of diabetes with diet and insulin a hopeful affair.

Thus in this day, "insulin has raised the expectancy of the lives of diabetic children from one to thirty-two years; it has practically abolished coma; and has doubled the duration of the disease for all diabetics." [10]

Before insulin, treatment of diabetes rested on diet alone. The mild diabetic managed fairly well; the severe case died in acidosis. The moderately severe diabetic just managed to eke out an hazardous existence. Most were always underfed, and consequently, unable to take an active, useful role in society. All were constantly in imminent danger from pregnancy, surgical operation, or infection of any sort.

The principle upon which the dietetic treatment revolved was based on a quantitative reduction of the total daily food intake as well as a quantitative rearrangement of its basic constituents (the carbohydrate, protein, fat) to such an extent, as to bring it within the limits of a lowered carbohydrate tolerance. When this is done, the body theoretically is called upon to oxidize only that amount of carbohydrate compatible with the degree of Islet dysfunction; consequently, there is no waste of glucose in the urine, the metabolism of fats and proteins proceeds to an end result, without the formation of any intermediate ketone bodies; furthermore, under such a regime the pancreas may recover some portion of its lost function.

These results, such as they were, could be accomplished of necessity only by abnormal diets, diets which were low in carbohydrates, low in total calories, and low in protein and ratioed fat. The introduction of insulin and its raising of carbohydrate tolerance allowed of higher carbohydrate diets, so that at the present time, these approximate those of healthy individuals; thus in Great Britain medical opinion[12] is rapidly accepting a two thousand calorie diet, of a type containing two hundred grams of carbohydrate with the proportion: carbohydrate 2, protein 1, and fat 1.

Such a diet is, of course, more convenient, more palatable, and increases the patient's subjective sensations of health and energy. According to Himsworth,[12] it renders the patient less liable to relapse and militates against the development of arteriosclerosis. With this view Rabinowitch and others are in accord. The seemingly theoretical objection, moreover, that proportionate increase in insulin dosage[12] would be required, is not borne out in practice; for only infrequently are a few more units necessary. These high carbohydrated diets have, it would seem, come to stay.

Insulin

What, we may ask ourselves, are the indications for the use of insulin? They can be stated quite precisely.[12] It must be given immediately to those whose urine contains enough ketone bodies to give a positive ferric chloride test; moreover, its administration must then be maintained at two hour intervals until the acidosis has been controlled, as determined by negative urine for a consecutive four to six hours, along with normal values for blood glucose and alkali reserve figures. It must be given, also, to those who, after a four day trial on a modern diabetic diet, pass urine which in the majority of specimens gives a positive nitroprusside test. It must be given, finally, to those who after a two weeks' period of dietetic treatment continue to show sugar in all urine specimens.

In these diabetics, thereafter, in their continued treatment, the dose of insulin may be systematically

altered up or down yet in tune with the requirements of a perfectly adequate nutrition and of a controlled metabolism. Nearly all patients[12] who first become aware of diabetes before middle age will require insulin within a period of two years; of those who acquire the disease in later life, about one-half will require insulin.

Let us submit to a critical eye the results achieved during the past sixteen years by the modern treatment of diabetes; and thus see what has been the accomplishment of scientific dietetics aided and abetted by insulin. The mild diabetics have been successfully carried along without insulin on a diet approximately normal. The severer cases[12] have required insulin in one, two, three, or even four doses a day, but at night they have still remained virtually uncontrolled.

The inability to control the severer cases during the night arises from the characteristic manner of action of regular insulin; that is, from its comparatively rapid, powerful, but transient effect. Large doses reduce the blood sugar to an undesirable hypoglycemia in from two to three hours, and yet practically lose all their physiologic action at the end of six hours.[12] Contrast this with the wondrously labile and delicate control exercised by the normal human organism, which, apparently governed by the level of the glucose in the blood, adds just the desired amount of insulin, be the need for it sudden and great, or but constant and small.

Protamine Insulin

Numerous investigators have appreciated the marked discrepancy between the action of normal pancreatic islands and that of injected regular insulin; and consequently, have sought to refine this obviously crude action by changing insulin itself. Finally, Hagedorn in 1936,[12] after many trials, hit upon a combination of insulin with a protamine from fish sperm, which at the hydrogen ion concentration of the body tissues would deliver insulin from a subcutaneous depot at a much slower rate. Scott[12] made still further modification by the addition of minute, non-toxic[13] amounts of zinc to protamine insulin, and found that his preparation would show its greatest effect in eight to fifteen hours as compared with protamine insulins of six to ten hours.

These new preparations have been since submitted to clinical trial by various groups of leading investigators, such as Joslin of Boston, Rabinowitch of Montreal, Wilder of the Mayo Clinic, and Himsworth of London; and have earned enthusiastic approval within certain definite limits.

Himsworth,[12] by comparing the action in the same patient of these preparations, found that under conditions where regular insulin would exert its maximum effect in two to three hours after injection, protamine insulin would show its maximum in six to ten hours and have worn off in twelve to eighteen hours; whereas zinc protamine insulin would show its greatest effect in eight to fifteen hours and still be rendering some service after twenty-four to thirty hours.

Advantages and Disadvantages

Accordingly, Himsworth[12] promulgates certain advantages and disadvantages which should be taken into account in any technique for their use. The prolongation of action allows of a reduction in the number of doses, and if either preparation be given in the late afternoon, it will effectively control the disease throughout the night. The longer acting zinc preparation will, at times in severer cases, do this better than the protamine insulin. Another salutary feature arises from the slowness with which the blood sugar is reduced; this action renders less likely the hypoglycemic attacks which frequently follow regular insulin when the latter's action has been potentiated by unusual exertion or exercise.

The very characteristics, though, that make feasible the above advantages, when not properly appreciated and applied, give rise to two distinct disadvantages. The first is the persistence and severity of the hypoglycemic attacks. These usually burst on the patient without warning, because the reduction of blood sugar has been so gradual as to produce no symptoms until the level reached is a dangerously low one. Moreover, because of the persistence of the action, it takes repeated and larger doses of carbohydrate to combat the attacks and to prevent relapses thereafter. The young are most susceptible to these hypoglycemic reactions; the aged, most free from them. The second disadvantage arises from the slowness with which these preparations swing into action. Thus they fail when given as a single pre-breakfast dose to prevent the glycosuria due to the rapid influx of glucose from the morning meal; injection of doses large enough to control such glycosuria invariably leads to hypoglycemic reactions in the night. Rec-

ognition of this, however, has resulted in the perfection of an appropriate technique.

Administration

Hagedorn and Krarup,[7] using the moderately slow acting protamine insulin, attempt to control only mild cases with a single daily dose. In the severer cases, they give the protamine insulin in the afternoon, thus holding the disease during the early evening and through the night; the next morning, the protamine effect still persisting, they add a dose of regular insulin, to take care of the rapid, post-breakfast glucose rise. This dose of regular insulin is considerably less than that necessary on a two dose regime of regular insulin. If the preceding modification still continues unsuccessful, they go further and rearrange the carbohydrate of the diet, so that breakfast contains twenty percent.; lunch, thirty percent.; tea, ten percent.; and dinner, forty percent.

The technique with the slowest acting preparation, zinc protamine insulin, is different still.[12] It has been worked out largely by the Canadians, Rabinowitch and Campbell, and in the United States by Lawrence and Archer. It consists of an initial pre-breakfast dose of the new preparation, plus a small dose of regular insulin. The combined dose is usually equivalent to the total daily requirements of the patient for regular insulin, and may, with proper precautions against mixing, be delivered as a single injection. The ordinary insulin controls the post-breakfast rise of glucose and has dissipated by the time that protamine zinc insulin is swinging into full effect; that is, about the time of the noon and evening meals. The effect, continuing as it does into the following morning, also holds the disease during the night, and makes the dose of regular insulin needed to control the post-breakfast rise a small one. Because of the fact that it may take several days for full therapeutic effects to be manifest, one should not increase or decrease doses by more than five units at two to three day intervals while seeking the optimum dosage. Also, in maintaining a proper balance, it may be necessary to re-apportion the carbohydrate of the diet, as heretofore mentioned, in order to lessen the carbohydrate load at the time of day when it is not well borne, and shift it to periods when it can be more readily utilized. It may even be desirable, in some instances, to give small amounts of food between meals or at bed time.

Himsworth[12] lists the following indications for the use of protamine and zinc protamine insulins: in cases where regular insulin has failed to control nocturnal glycosuria; where exercise is especially liable to produce hypoglycemia; and where the reduction of the number of injections is desired.

It is to be noted, in closing, that these slow acting insulins are not suited for the treatment of coma or states of severe acidosis where prompt action is required.

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SPONTANEOUS SUBARACHNOID HEMORRHAGE

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We are reporting seven cases of Spontaneous Subarachnoid Hemorrhage. This disease is characterized by the sudden onset of apoplectiform headache, mild stiffness of the neck, double Kernig's sign, a bit of fever, and bloody spinal fluid. Although Samuel Wilks, in 1859, first applied the term "spontaneous" to such "sanguineous meningeal effusions," the first clear description of the clinical syndrome was given by Byron Bramwell in 1886. With the advent of lumbar puncture done more routinely in cases with head signs there has been in the last few years a greater orientation to this condition and the recognition of many more

cases. The bloody effusion in the subarachnoid space comes from a ruptured aneurysm of one of the arteries at the base of the brain. The literature contains many reports on the disease, Spontaneous Subarachnoid Hemorrhage. It is not infrequent; recently we had four cases under observation at the same time. Of the cases here reported two are given in detail and five in brief:

Patient No. 1: M. G., a moderately obese, forty-three-year-old, married, Jewish salesman was seen in consultation with Dr. Garside on March 7, 1937, and sent to the Charles V. Chapin Hospital the following day.

He had never been ill till one week before admission, when he was seized during coitus by a severe occipital pain radiating up into his head and down into his thighs. He drove to a doctor's office; on the way he vomited and felt better. The pain in the head persisted, and when first seen by Dr. Garside, four days later, there was fever, diminution of deep reflexes, and a slightly positive Kernig's sign. He was becoming weaker and was unsteady in gait. There was no hypertension, no convulsions or blurring of vision.

On the seventh day, the day of the consultation, the patient had severe headache, stiff neck, a double Kernig, blurred disks without hemorrhages, absent patellar, biceps, and abdominal reflexes. Sensorium was clear.

On admission to the hospital he showed bloody spinal fluid, which had 23,700 red cells per cu.mm., a pressure of 570 mm. water, negative Wassermann, and was sterile on culture. The blood Wassermann and Hinton were negative. Urine had a heavy trace of albumen, a few red and white cells, and no casts. After the first lumbar puncture, the patient got great relief, and on subsequent lumbar punctures red cells and headache gradually decreased. The spinal fluid had 10,000 red cells on the second day in the hospital, 12,500 on the third day, 4,000 on the sixth day. On the thirteenth day he left the hospital without headache, without mental signs, and with a slight left facial weakness as the only nerve complaint.

This patient showed the typical clinical syndrome of Spontaneous Subarachnoid Hemorrhage: (1) sudden severe headache, (2) mild neck sign, (3) moderate double Kernig, (4) a bit of fever, (5) bloody spinal fluid.

Patient No. 2: A. W., a thirty-two-year-old, husky, married, Irish-American cost-estimator was admitted to the Charles V. Chapin Hospital on February 13, 1937, and was seen in consultation with Dr. Kiene at that hospital on February 24.

As a young man he had been successful and his past history showed no illnesses excepting a foul ear discharge, which had persisted since thirteen years of age, at which time he had broken his right ear drum while diving.

The night before admission he went to bed well. At one-thirty his wife was wakened by the patient's loud snoring, which became stertorous, deep, and regular. He was staring into space, frothing at the mouth, snorting through the nose, and could not be aroused to consciousness. He thrashed around in bed so violently that he had to be lowered onto the floor, where he continued to grovel. His violence was becoming so great that he was sent to the Psychopathic Ward of the Charles V. Chapin Hospital.

A short time after admission he was more conscious and complained of pain in his head, intermittent and accompanied by restlessness. His neck was stiff; Kernig's sign was not noted; the spinal fluid was bloody, with a red cell count of 450,000/cu.mm., a pressure of 200 mm. of water, and a negative Wassermann. He was sweating profusely and vomited brown-black material. The pulse was full and slow (60), temperature 99.4, respirations 22, blood pressure 130/90. The reflexes were equal and active, with absent abdominals and bilateral Babinskis. Blood Wassermann and Hinton were negative; the urine had a 2-plus sugar reaction and a heavy trace of albumen. On the third day he was considerably improved; the spinal fluid had 145,000 red cells/cu.mm. His neck was still stiff; but the abdominal reflexes were lively, although the positive Babinski persisted on the right. On the fourth day the spinal fluid red count had dropped to 48,000. On the sixth day the fundi showed only congestion and edema of the periphery of the retina. He was still restless and confused on the seventh day, when the spinal fluid red count had dropped to 24,000. On the ninth day he was less drowsy but failed to answer questions. He recognized objects but couldn't name them. He would take a pencil into his left hand and make aimless and grotesque lines. He knew how to light and what to do with a cigarette but would not or could not mention its name. There was a right hemiplegia with aphasia; the leg was more spastic than the arm, and the face was only slightly involved. Right abdominal reflexes were absent, and there was a Babinski on the right. The

neck was still stiff. On the tenth day the fundi were normal, the right hemiplegia was complete, but the spinal fluid was xanthochromic with only 44 red cells/cu.mm. and a pressure of 50 mm. water. He was still confused, saying only "yes" and "no." The aphasia persisted, and on the twenty-fifth day there was a convulsion, more marked on the left side, with generalized rigidity, vomiting, defecation, micturition, and profuse perspiration. The spinal fluid had 500 red cells/cu.mm. and a pressure of 240 mm. water. One-half hour after the convulsion the pulse was 90 and the blood pressure 128/76. Within the next hour there were two more convulsions accompanied by stertorous Cheyne-Stokes respirations and a weak pulse. Though at first comatose, he improved after the removal of 10 cc. of bloody spinal fluid but soon returned to a stuporous state. He went downhill rapidly thereafter. On the twenty-sixth day there was projectile bilious vomiting. The right hemiplegia persisted. On the thirtieth day he became stuporous. The spinal fluid was again very bloody, with 100,500 red cells/cu.mm. and a pressure of 500 mm. water. The pulse was 104 and the temperature 102.4. The temperature reached 107.6 on the thirty-second day, the spinal fluid red count was 100,200/cu.mm., and he died.

This patient showed headache of sudden onset, with vomiting, a stiff neck, and a bloody spinal fluid, giving the syndrome of SUBARACHNOID HEMORRHAGE.

At autopsy there was a ruptured aneurysm of the anterior communicating artery at the junction with the left anterior cerebral artery.

Patient No. 3: W. F., a thirteen-year-old, white, American schoolboy entered St. Joseph's Hospital January 30, 1937, on the service of Dr. Jordan with Dr. McCaffrey and Dr. McDonald consulting. A diagnosis of "Subarachnoid Hemorrhage" was made on the patient, who had had good health previously. While in the hospital the patient vomited without nausea. Blood pressure was 110/60. He looked sick. Bilateral Kernig. Spinal fluid bloody. Vision and fundi normal. Blood Wassermann negative. Urine had 1-plus sugar and positive reaction for acetone. Recovery after spinal fluid drainage. Home on 35th day.

Patient No. 4: J. P. S., a thirty-three-year-old, Irish-American bookkeeper. In good health. While taking shower seized with dizziness, became unconscious, and fell. Day before had been a bit dizzy with "funny feeling" in head. Blood pressure 116/90. Blood Wassermann negative. Blood sugar normal. Later convulsions and hemiplegia. Spinal fluid showed large amount of blood. Urine negative. Coma increased. Spinal fluid continued to be bloody. Death on second day of sickness.

Patient No. 5: F. P., a forty-seven-year-old, French-Irishman. Enjoyed good health. Ate big breakfast and walked to work. In his office slumped and fell to floor. Patient in coma, showed stiff neck, double Kernig, some fever, negative fundi, moderately elevated blood pressure. Urine not abnormal. Spinal fluid under terrific pressure. Death day of attack.

Patient No. 6: E. G., a twenty-one-year-old, unmarried, female, bookkeeper. Admitted to Woonsocket Hospital. Dr. Rocheleau and Dr. McDonald consulting made a diagnosis of "Subarachnoid Hemorrhage." On day of admission had headache, unconsciousness, and vomiting. Moderate stiffness of neck, double Kernig. Blood pressure 110/80. Urine albumen 3-plus. Bloody spinal fluid. After several spinal taps blood decreased, comfort increased. Patient discharged, well.

Patient No. 7: M. McC., a thirty-three-year-old unmarried, female housekeeper. Had not felt well for some time with an occasional weak spell. Good general practitioner, who had treated her for some time for various complaints including headache, found no definite disease. While drinking at soda fountain, fell. Became unconscious and remained so. When seen in consultation had blurred disks, stiff neck, Kernig's sign. Bloody spinal fluid. Death next day without regaining consciousness.

Discussion

These cases are selected and reported to call attention to the frequency of the disease and its occurrence in patients without arteriosclerosis with hypertension, or neoplastic or anemic disease which bleeds. Four of the patients died and three recovered. Their respective ages were 32, 33, 33, 47, 13, 21, and 43 years. None of them were known to be sick before the apoplexy. All of them showed symptoms and signs which led to recognition of the disease during life.

Conclusion

SPONTANEOUS SUBARACHNOID HEMORRHAGE is not an uncommon condition and can be readily recognized by the syndrome of sudden severe headache, stiffness of the neck, double Kernig's sign, a bit of fever, and a bloody spinal fluid.

THE RHODE ISLAND MEDICAL JOURNAL



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AMERICAN MEDICINE—EXPERT TESTIMONY OUT OF COURT

Every practitioner of medicine is aware that as a part of general unrest and dissatisfaction with much of the social and economic life of the country there is specific criticism of the present status of medical practice. Most of the profession are more or less familiar with the inquiry as to the costs of medical care. Now there is presented a new and quite different kind of report by the American Foundation. This inquiry was undertaken as a part of the Foundation's Studies in Government, their particular concern being the relation of government to health—"with no assumption either that government should or should not play a larger part than it now plays."

As an initial step in the study of this question a wide appeal was made to the medical profession. In essence the inquiry addressed to individual physicians was as follows: "Has your experience led you to believe that a radical reorganization of medical care in this country is indicated? If so, in what direction? If you do not believe that radical reorganization is indicated, what, if any, changes or revisions in the present system would you like to see made? What evolutionary possibilities would you stress?" The letter containing this inquiry was sent to physicians in all parts of the United States and the large two-volume report is founded entirely on their answers. The intention was to make the replies really representative of the whole profession. It would appear that that result has been achieved, as general practitioners, specialists, teachers and public health officials are well represented; in fact, 289 general practitioners and 305 clinical professors are found among the contributors.

While the report cannot be said to have brought to light anything like a unanimity of opinion on any of the subjects which are involved it does yield certain very valuable results. Of these we may pick out a few which will, perhaps, stimulate readers of the JOURNAL to consult the report itself. In the first place, although there is no general agreement on what constitutes "adequate" medical care, the weight of opinion is certainly that such care is by no means available to all the American people. Among the reasons for this are (1) that it costs too much, (2) that it is in many instances too far away, especially in certain Western and Southern States, (3) that the public generally does not understand or desire it, preferring quacks, cults and patent medicines, and (4) that medical training and post graduate instruction must be improved before it can be considered really adequate. The sections on Medical Education, Specialization and Group Practice are very illuminating. As to *State Medicine*, it is quite evident from the replies that any really thorough-going system, i.e., government paid and controlled physicians, would be more than inadequate and would involve the likelihood of political control, the loss of efficiency and the destruction of the "doctor-patient" relationship, the importance of which as a real therapeutic factor is stressed in many of the letters. In the same way it is evident that a plan for *compulsory health insurance*, which after all touches only the economic side of the problem, cannot be considered as an adequate solution. It cannot answer the needs of the actually indigent or the special problems of the rural or farming communities nor does it concern itself at all with the *quality* or adequacy of the medical care provided, nor with questions of preventive medicine. A plan for *Limited State Medicine*, integrated with private practice without encroaching upon it, developing the principle that community health as a whole

is chiefly the concern of the State whereas the problem of the individual belongs to the practicing physician; a plan also with added provisions for tax support for hospitals generally and the establishment of a *Federal Department* of *Health* seems to be the most constructive idea that one can extract from the mass of varying opinions that are given in the report.

MUSCULAR CONTROL

Again the popular publications, *Time* and *Life* (April 5 and 12, respectively) have called attention to, and excellently presented, a subject that should be of intense interest to the medical profession. It is a subject that has been sadly neglected or at least advanced with but unsatisfactory results in general. We refer to postural development. The above mentioned articles present some of the principles of the Mensendieck system of exercises for improving posture and grace. Anyone who interests himself in the matter cannot but be struck by the fact that the posture of a large percentage of young adults is poor, frequently little short of abominable.

Schools and colleges today are emphasizing the importance of training the body as well as the mind. The long-standing tendency to give dumb-bell or weight-pulling or similar exercises still persists. These are frequently given for the purpose of strengthening the muscles used in some specialized form of athletics without careful attention to the muscles used in normal activity. While athletics certainly serve a useful purpose, we are destined to spend a good deal of our life standing, sitting, walking and going through various relatively quiet motions in pursuit of a living. But how many of us know how to do these things in a manner that holds the various elements of our frame in the proper relationship one to the other? Very few. These exercises frequently result in the over-development of certain muscles, thus producing an improperly coordinated whole. Such muscles soon become flabby and serve little useful purpose when the individual leaves his or her physically active life in favor of the less athletic post-academic career.

There are many factors that work against the body's demand for a properly balanced structure. Not the least of these is the tendency so many of us have to be careless of our posture, in fact frequently to develop intentionally a nonchalant slouch or lordotic stance. These are anything but conducive to good postural development. What good can exercises performed for a period of but an hour or so do if we spend the rest of our fourteen to sixteen waking hours in putting our bodies through all sorts of disadvantageous positions? It is no wonder that so many men and women of middle age find their bodies unequal to the task of comfortably and efficiently housing the vital organs, these organs that have otherwise been put to many severe tests by the abuses the ordinary person throws upon them.

The human body with its erect bipedal posture and its intricate opposing sets of muscles is a unique problem in mechanics. Upon it we depend largely for our conquests over the other elements of nature. It is given us to do what we will with it. What most of us do is insult it repeatedly and then wonder in our middle age why it causes us so much fatigue and pain. We make little attempt to learn how to use the muscles provided for keeping the various structures in the proper alignment to establish and to maintain the necessary line of weight-bearing. In fact few of us ever consider seriously that such a training is particularly valuable. The body is taken for granted and our time is spent in trying to adjust our environment to our liking. But it is true and, when we stop to think about it, obvious that properly to balance such a complex system demands a certain amount of careful training. The proper tonus must be maintained between these opposing sets of muscles in order to diminish wear and tear on the innumerable working parts of our well integrated skeletal system and to keep our internal organs in the optimal relationships. True, the human form will stand a remarkable amount of punishment, but it can return this with interest when maltreated. For this we cannot blame it.

Dr. Mensendieck has long appreciated the necessity of giving the body a chance. Her system of exercises is based on learning to control and to use to advantage many muscles that most of us do not realize exist, except that we once learned them in anatomy. To learn the system requires considerable training and drilling, but strenuous exertion is avoided. Once learned, the use of these muscles can readily become second nature, be made a part of our daily activities throughout life. While we are carrying on our normal activities, we are at the same time doing our exercises, subconsciously keeping our bodies fit supporters for our inner struc-

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Mensendieck: System of Functional Exercises, Southworth-Anthoensen, Portland, Maine.

tures. These exercises are chiefly designed to promote grace, but grace is essentially dependent on rhythmically coordinated movements. This is another way of saying that grace is a labor-saving device designed to get the most out of the body with the least expenditure of energy. The graceful body should last longer. A more general application of such a system in institutions dealing with youth and a better example set by the various means at our disposal should pay good returns in diminishing future suffering. But the training should not be confined to youth; adults can also benefit from it.

LATIN FLOWERS OF MEDICINE

Sulzberger and Wise, in October, 1932, published an article with the heading, "Lymphopathia Venereum."[1] The same authors, shortly after, regretted what they called the mistake of putting together a feminine noun with a neuter adjective and said that the proper heading should have been "Lymphopathia Venerea," in order to have the adjective agree with the feminine noun.[2] Since then a number of articles have appeared with the corrected heading, "Lymphopathia Venerea,"[3] but others have persisted in using the title, "Lymphopathia Venereum."[4] "Lymphopathia Venereum" is still listed in the Quarterly Index Medicus. Waintraub quotes Neisser as the creator of the flower "Leukoderma Syphilitica" and says, without comment, that the above heading has been freely used in Germany and it is still used by English dermatologists.[5]

American editors have the reputation of going over every word and every letter in any foreign language and of correcting anything that may have escaped the attention of the author. European editors have not such a reputation, probably because they cannot afford the expense of a highly trained editorial staff. In this particular instance the memory of elementary Latin seems to have completely vanished.

1. The Journal A. M. A., 99, 17, 1407, Oct. 22, 1932.
2. Idem., 99, 22, 1880, Nov. 26, 1932.
3. Trans. Am. Proct. Soc., 1934, p. 150. Southwest Med., 19, p. 103. Cal. & West. Med., 42 p. 176. Texas State Med. Jour., 29, p. 192.
4. Urol. & Cut. Review, 37, p. 786, Nov. 1933. Am. Jour. Med. Sc., 190, p. 178, August, 1935. Surg. Gyn. & Obs., 62, p. 745, April, 1936. The Journal A. M. A., 106, p. 1869, May 30, 1936. Ann. Surg., 104, p. 279, August, 1936.
5. Annales des Maladies Veneriennes, 32, p. 81, Feb. 1937.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the May Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Peter Pineo Chase, on Monday, May 3, 1937, at 8:35 P. M. The minutes of the last meeting were read and accepted.

The Standing Committee having approved his application, Dr. James Thomas Fallon was elected a member of the Providence Medical Association.

Dr. H. G. Partridge read an obituary of the late Dr. James H. Akers. It was voted to spread this on the records and to send a copy to the family.

The first paper of the evening was by Dr. George A. Moore, of Brockton, Massachusetts, who spoke on "Intestinal Tuberculosis." The paper was discussed by Dr. Edwin D. Gardner of New Bedford, Massachusetts, and by Dr. Gerber.

Dr. Richard H. Miller, Clinical Professor of Surgery at Harvard Medical School, was prevented from giving his paper because of injuries received in an automobile accident. The second paper of the evening, therefore, was presented by Dr. Alex. M. Burgess, who spoke on "The Use of 98% Oxygen in Gaseous Distension of the Intestine Especially in Pneumonia." The paper was discussed by Doctors John F. Kenney and Benjamin.

Dr. Roland Hammond then demonstrated a new method of strapping fractured ribs.

The meeting adjourned at 10:10 P. M. Attendance, 132. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D.,
Secretary

The American Board of Surgery

In answer to the widespread demand for an agency which will attempt to certify competent surgeons, the American Board of Surgery has recently been organized.

The following have been chosen as the members of the Board: Dr. Evarts A. Graham, Dr. Arthur W. Elting, Dr. Allen O. Whipple, representing the American Surgical Association; Dr. Donald Guthrie, Dr. Erwin R. Schmidt, Dr. Harvey B. Stone, representing the American College of Surgeons; Dr. Fred W. Rankin, Dr. Howard M. Clute, Dr. J. Stewart Rodman, representing the Surgical Section of the A. M. A.; Dr. Philemon E. Truesdale,

representing the New England Surgical Society; Dr. Thomas Orr, representing the Western Surgical Association; Dr. Robert Payne, representing the Southern Surgical Association; Dr. Thomas Joyce, representing the Pacific Coast Surgical Association. The following officers have been elected: Chairman, Dr. Evarts A. Graham; Vice-Chairman, Dr. Allen O. Whipple; Secretary-Treasurer, Dr. J. Stewart Rodman.

Two groups of candidates are recognized for qualification by the Board: (a) Those who have already amply demonstrated their fitness as trained specialists in surgery. (b) Those who, having met the general and special requirements exacted by the Board, successfully pass its qualifying examination.

The first of these groups, the Founders Group, upon invitation by the Board, will be chosen from the following: (1) Professors and Associate Professors of Surgery in approved medical schools in the United States and Canada. (2) Those who for fifteen years prior to the Board's organization have limited their practice to surgery. (3) Members of the American Surgical Association, the Southern Surgical Association, the Western Surgical Association, the Pacific Coast Surgical Association and the New England Surgical Society, who are in good standing January 9, 1937. All applications for the Founders Group must be received within two years of the Board's organization, January 9, 1937. No candidates for the Founders Group will be considered after that date.

Requirements for those to be qualified by examination will be as follows: (1) Graduation from a medical school of the United States or Canada recognized by the Council on Medical Education and Hospitals of the A. M. A. or graduation from an approved foreign school. (2) Completion of an internship of not less than one year in a hospital approved by the same Council, or its equivalent in the opinion of the Board. (3) *Special Training.* A further period of graduate work of not less than three years devoted to surgery taken in a recognized graduate school of medicine or in a hospital or under the sponsorship accredited by the American Board of Surgery for the training of surgeons. This period of special training shall be of such character that the relation of the basic sciences of anatomy, physiology, pathology, bacteriology and biochemistry is emphasized. Knowledge of these sciences as applied to clinical surgery will be required in the examination. Adequate operative experience in which the candidate has assumed the whole responsibility will be required. An additional period of not less than two years of study or practice in surgery. (4) The candidate must present to the Board sufficient evidence of good moral character as to justify it in the belief that he will not engage in fee splitting and other dishonest practices.

The qualifying examination will be divided into two parts: Part I, written, and Part II, clinical, bedside and practical. The written part, Part I, will concern itself with general surgical problems and with the clinical application of the basic sciences of surgery to these problems. This examination will cover a period of three hours each and will be held simultaneously in as many centers as are necessary to accommodate the number of applicants who are eligible. Part II is entirely oral and will also concern itself, in the main, with general surgery and, as stated for Part I, clinical application of the basic sciences to the clinical problem represented. In addition to this, in Part II an examination will be given to test the candidate's knowledge of operative surgery, X-ray plate interpretation and the principles and application of surgical anesthesia. This examination will be held in as many centers as the Board may determine necessary to accommodate the eligible candidates. Re-examinations will be allowed, provided one year shall elapse between examinations.

The fee for Group A, the Founders Group, will be $25. The fee for Group B will be $75, payable as follows: $5 for registration fee, which shall be returned if the candidate is not accepted for examination; $20 for Part I; and $50 for Part II. The same fee will be required for each re-examination. Once the candidate has become qualified, he will have no further financial obligation to the Board.

The Board will hold its first examination on September 20, 1937. Requests for application blanks and other information should be addressed to the Secretary, Dr. J. Stewart Rodman, 225 South 15th Street, Philadelphia, Pennsylvania.

The American Board of Ophthalmology will conduct an examination in Philadelphia, June 7, 1937; Chicago, October 9, 1937. All applications and case reports, in duplicate, must be filed at least sixty days before the date of examination with John Green, M.D., Secretary, 3720 Washington Boulevard, St. Louis, Mo.

RHODE ISLAND SOCIETY FOR NEUROLOGY AND PSYCHIATRY

Minutes of the April Meeting

The April meeting of the Rhode Island Society for Neurology and Psychiatry was held at the John M. Peters House, Rhode Island Hospital, on April 12, 1937. The meeting was called to order at 8:40 P. M. by the President, Dr. Jerome J. McCaffrey. The minutes of the last meeting were read and approved. The application of Dr. H. W. Williams having been approved by the Standing Committee, he was elected to membership.

The first paper of the evening was presented by Dr. C. C. Hare, of New York City, Assistant in Neurology in the Neurological Institute and Associate Professor of Psychiatry at Columbia University. His subject was, "Metastatic Involvement of the Brain."

Dr. Hare gave a careful and complete analysis of cases which had been studied recently at the Neurological Institute. He presented his data from many angles. He considered the symptoms, the lesions, and the foci of the original tumor. Lantern slides were presented of the tissues, showing particularly the relation of the tumor to brain tissues, the metastases often being at the junction of the white and gray substances. He stressed that frequently malignancies of the lungs or bronchi were accompanied by brain metastasis. The diagnosis was often difficult, this difficulty being increased by multiple tumors. While several in the series had been operated upon, Dr. Hare felt that, with a fairly definite diagnosis, operative treatment was not to be particularly considered.

Dr. Hare's paper was so complete that any abstract is quite unsatisfactory. His paper was discussed by Dr. Nichols, Dr. C. A. McDonald, Dr. Philip Solomon, and Dr. W. N. Hughes, who pointed out the value of the paper, hoping that it would be published and then would be available for study.

The second paper of the evening was presented by Dr. Vincent P. Rossignoli, on "Sodium Amytal as a Substitute for Tube Feeding." Dr. Rossignoli has studied the effect of sodium amytal on the mental patient who does not eat. He finds that the use of sodium amytal changes the reaction of the patient so that he or she becomes more co-operative, is in better contact, and tube feedings can be dispensed with.

This paper was discussed by Dr. Kiene and others present.

Meeting adjourned at 11:15 P. M. and was followed by a collation.

Respectfully submitted,
NILES WESTCOTT, M.D., *Secretary*

RHODE ISLAND ASSOCIATION OF RECORD LIBRARIANS

The Rhode Island Record Librarians' Association was organized on October 15, 1935. The officers are: President, Miss Irene Cavanaugh, Providence Lying-In Hospital; Vice President, Mrs. Ellison Creighton Frazier, Rhode Island Hospital; Secretary-Treasurer, Miss Elizabeth Bingham, St. Joseph's Hospital.

Misses Kempton and Dorothy Pillion represent the Charles V. Chapin Hospital; Miss Madeline Fournier, the Emma Pendleton Bradley Home; Miss Sarah Litwin, Miriam Hospital; Miss Elizabeth Bingham, St. Joseph's Hospital; Mrs. Ellison Creighton Frazier and Miss Helen Jackson, Rhode Island Hospital; Miss Agnes Deasy, R.N., Homeopathic Hospital; Miss Mary Nunez, Memorial Hospital; Mrs. Doris Champagne, Woonsocket Hospital; Miss Mary Harrold, R.N., Westerly Hospital, and Miss Evelyn Parry, R.N., Newport Hospital.

Meetings are held the third Tuesday of every month at the Rhode Island Medical Library. The Association aims to seek uniformity in the various procedures adopted in hospital record rooms, particularly in the manner of record keeping and filing; it also aims to be of service to the Record Librarians of each hospital and sincerely hopes to encourage discussion leading to the adoption of such uniform procedures.

In October, 1936, four members attended the Annual Convention of the Record Librarians of North America. They were Miss Irene Cavanaugh, Providence Lying-In Hospital; Miss Adriel Murphy and Mrs. Ellison Creighton Frazier, Rhode Island Hospital, and Miss Evelyn Parry, R.N., Newport Hospital.

Dr. Joseph Smith from the Health Department of the City Hall spoke to us on Birth and Death Returns. His talk proved interesting and was of great value.

During the year, we have held meetings in the Record Department of the Rhode Island Hospital

and the Westerly Hospital. At these meetings the Record Rooms were inspected and much information was gathered regarding the systems in vogue at that particular hospital.

In March, 1937, the meeting was held at the State Hospital. Mr. Nicholas Janson, Chief Clerk, showed us where the records of the patients were kept and the manner in which they were recorded.

Respectfully submitted,

ELIZABETH M. BINGHAM,
Secretary

NATIONAL SOCIETY FOR THE ADVANCEMENT OF GASTROENTEROLOGY

An open meeting of the National Society for the Advancement of Gastroenterology was held at the Medical Library on Thursday, May 13, at 8:30 P. M. and was attended by many Fellows of the Rhode Island Medical Society. Dr. Frank A. Cummings, President of the Rhode Island Chapter, presided and introduced the several speakers. Dr. Roy Upham, Professor of Gastroenterology at the New York Medical College and Flower Hospital, spoke on "The Cholecystectomized Invalid." He encounters these individuals too often in his practice and lays the blame for their predicament on "the present scourge of incompetent surgery." Dr. Anthony Bassler, President of the National Organization, gave "Case Reports and Discussion." He detailed a case of diarrhœa cured by vaccine, one of ascarides not relieved by multiple abdominal operations, several cases of post-operative hepatic deficiency, and one of diaphragmatic hernia relieved without operation. Dr. Samuel Weiss, Professor of Gastroenterology at the New York Polyclinic, gave a practical address on "Newer Synthetic Drugs in the Treatment of Biliary Disease."

The discussion was opened by Dr. Charles W. McClure of Boston. Dr. Arthur T. Jones stressed the importance of examination of the bile ducts during gallbladder operations. Dr. Frederic V. Hussey outlined possible causes of failure in gallbladder surgery and showed lantern slides which demonstrated post-operative spasm of the choledochal sphincter.

The annual meeting of the American Association for the Study of Goiter will be held in Detroit, Michigan, June 14, 15, 16, 1937, with headquarters at the Book-Cadillac Hotel. Dr. W. Blair Musser, Kane, Pa., is the Corresponding Secretary.

Local Events

May 11.—Dr. Herbert G. Partridge entertained the Amos Throop Medical Club at Hearthstone House. Dr. Harry C. Messinger presented a paper on "The Role of Vitamins in the Eye."

May 14.—At the regular meeting of the William W. Keen Medical Club, Dr. William P. Davis read a paper on "Acute Gall Bladder Disease in Childhood."

May 17.—Dr. Frank B. Cutts entertained the Thirty-four Medical Club at his residence on Rochambeau Avenue. He presented a paper on "Surgery in Patients with Heart Disease." In a review of recent literature on this subject, he noted Marvin's opinion that "a heart which is damaged but is capable of meeting the ordinary demands of daily life is the equivalent of a normal heart for the purposes of anesthesia and operation." Dr. Cutts concluded, "As a general rule it is quite safe to expect that, with the exception of syphilitic aortic regurgitation, a heart will survive anesthesia and operation successfully if it produces no symptoms in carrying out the demands made on it in ordinary life."

May 18.—The sixth lecture in the series arranged for the General Staff of the Homeopathic Hospital of Rhode Island was given by Dr. W. Richard Ohler on the subject, "More About Medical Odds and Ends."

May 26.—The regular monthly meeting of the Jacobi Medical Club was held at the Miriam Hospital Annex at 8:45 P. M. Dr. Max Davis of Boston addressed the Club on "The Use of Endocrine Products in Gynecology and Obstetrics."

Providence Lying-In Hospital

Interest in the course of clinical lectures sponsored by the Rhode Island Medical Society and given at the Providence Lying-In Hospital is shown by the increasing attendance. The first lecture of the series, on May 6, was given by Dr. Edward S. Brackett, with the subject, "The General Practitioner and His Obstetrical Problems." The speaker was introduced by Dr. John G. Walsh. Dr. John E. Donley, President of the Rhode Island Medical Society, in an introductory address, extended congratulations and greetings from the State Society. Analyzing 350 maternal deaths in Rhode Island, Dr. Brackett summarized the general practitioner's

possible contribution to reduced maternal mortality. He stated that the obligation of the specialist is to improve himself and to spread improvements in his specialty.

On May 13, Dr. Paul Appleton spoke on "Prenatal Care." He emphasized the need for personal contact between obstetrician and patient before the time of delivery. He spoke of the importance of pelvimetry, of regard for the premonitory signs of toxemia, and of diagnosis of the posture and presentation, all tending to bring the patient to term in the best possible condition.

On May 20, Dr. George W. Waterman spoke on "Difficult Labor." He emphasized the importance of pelvic measurement and illustrated the different types of pelves with lantern slides. He then described the maternal and fetal causes of dystocia and outlined the treatment appropriate for each condition.

The fourth lecture was given by Dr. Bertram H. Buxton, Chief of Staff, on May 27. His subject was "Management of Obstetrical Hemorrhage."

The final lecture will be given on June 17, at 11 A. M. The speaker will be Dr. Alfred L. Potter and his subject, "Toxemias of Pregnancy." These lectures have proved to be of such interest and value that a second course is contemplated.

Woonsocket Hospital

The regular Staff meeting was held at the Woonsocket Hospital on April 12, 1937, with Dr. T. Frank Kennedy presiding. The following cases were presented: meningococcic meningitis; malignant fulminating foudroyant infection, duration twenty-four hours, Dr. Emidy; Carcinoma of left lung, duration two years, Dr. Monti; the following paper was presented by Dr. Paul E. Boucher and its discussion was opened by Dr. J. V. O'Connor, "Histidin Treatment of Peptic Ulcer."

The monthly Clinical Conference was held at the Woonsocket Hospital on April 26, 1937, with Dr. Henri E. Gauthier acting as chairman. Dr. O'Connor presented the first case: "Questionable Addison's Disease." Dr. Henri E. Gauthier discussed the above-mentioned case. The second case, one of "Amyotonia Congenita," was presented by Dr. L. H. Emidy and the discussion was indulged in by several members.

The May meeting of the Woonsocket Hospital Staff was held on the 12th. Dr. T. Frank Kennedy presided. This meeting was entirely devoted to hospital problems and the Medical Staff, after outlining a very comprehensive plan, asked for suggestions and constructive criticisms of their proposals.

Hospital News: The annual appeal for funds netted the tidy sum of more than $26,000. For a community of its size, Woonsocket should be proud of this magnificent result.

Butler Hospital

Butler Hospital was "At Home" to its Board of Incorporators and friends on Friday afternoon, May 21st.

It has long been felt by the Trustees and Superintendent that many misconceptions with respect to mental disorder still existed in the public mind. Having this in view, the afternoon's program was planned to be educational. In Ray Hall were arranged a number of exhibits showing in graphic and pictorial fashion the various activities of the hospital as they are carried on in the ordinary daily routine. These exhibits included an occupational therapy department for men and women in actual operation; also clay modeling as it is done in that department. Physiotherapy apparatus was displayed and its uses indicated. The School of Nursing had a graphic pictorial display, indicating what actually goes on in the hospital at 9:30 A. M. on an ordinary working day. The sources from which nurses come for affiliation and for postgraduate work were shown on maps and a large world globe. The work of the business office and the Social Service Departments was illustrated in a very interesting and practical fashion. Modern methods of diagnosis, as exemplified by psychological testing and electro-encephalography, were demonstrated, and the tests actually given. A very interesting and informative moving picture, showing many hospital activities which are impossible to show by means of an exhibit, proved very attractive and popular with the visitors. A tour was arranged through the hospital wards for those desiring it. The resources of the staff were taxed to the utmost to keep up with the demands for visits to the wards, library, and other facilities of the hospital. The department in charge of the patients' recreations, in addition to a very interesting display in Ray Hall, contributed an athletic program for the afternoon.

Between 600 and 700 visitors took advantage of the opportunity to inform themselves about the

work of the hospital and the treatment of mental disorder.

So far as is known, this is the first attempt of this sort ever made by a mental hospital to open its doors and familiarize the public with the actual therapeutic and diagnostic procedures used in the present day management of mental disorder. It is felt that this serves a very valuable purpose in the broad program of educating the public in medical matters, and should tend toward a better understanding of mental illness.

From the many inquiries and favorable comments of visitors, it is believed that this objective was adequately achieved, and the Trustees and Superintendent of Butler Hospital are to be commended on their progressive policy and their achievements in keeping abreast of the present in mental medicine.

Rhode Island Hospital

SCHEDULE FOR JUNE, 1937

Tuesday, June 1
10:00 A. M. II Surgical Grand Rounds
7:30 P. M. Internes' Path. Conference
Wednesday, June 2
10:00 A. M. Tumor Clinic
12:00 Noon Skin Clinic, Peters House
Thursday, June 3
8:45 A. M. to 12:45 P. M. Surgical Clinics
12:00 Noon Thoracic Clinic
12:45 P. M. Luncheon
Friday, June 4
11:00 A. M. Fracture Rounds
11:30 A. M. Heart Conference
Saturday, June 5
9:00 A. M. Neurological Grand Rounds
10:00 A. M. Medical Conference
Monday, June 7
10:00 A. M. II Surgical Grand Rounds
4:30 P. M. Thoracic Clinic
Tuesday, June 8
10:00 A. M. I Surgical Grand Rounds
Wednesday, June 9
10:00 A. M. Tumor Clinic
12:00 Noon Skin Clinic, Peters House
Thursday, June 10
9:00 A. M. Orthopedic Grand Rounds
12:00 Noon Thoracic Clinic
Friday, June 11
11:00 A. M. Fracture Rounds
11:00 A. M. Pediatric Grand Rounds
11:30 A. M. Heart Conference
7:30 P. M. G. U. Meeting
8:30 P. M. Surgical Staff Meeting
Saturday, June 12
9:00 A. M. Neurological Grand Rounds
10:00 A. M. Medical Conference
Monday, June 14
10:00 A. M. I Surgical Grand Rounds
4:30 P. M. Thoracic Clinic
Tuesday, June 15
10:00 A. M. II Surgical Grand Rounds
7:30 P. M. Internes' Path. Conference
Wednesday, June 16
10:00 A. M. Tumor Clinic
12:00 Noon Skin Clinic, Peters House
Thursday, June 17
9:00 A. M. Orthopedic Grand Rounds
12:00 Noon Thoracic Clinic
Friday, June 18
11:00 A. M. Fracture Rounds
11:30 A. M. Heart Conference
Saturday, June 19
9:00 A. M. Neurological Grand Rounds
10:00 A. M. Medical Conference, Peters House
Monday, June 21
11:00 A. M. II Surgical Grand Rounds
4:30 P. M. Thoracic Clinic
Tuesday, June 22
10:00 A.M. I Surgical Grand Rounds
Wednesday, June 23
10:00 A. M. Tumor Clinic
12:00 Noon Skin Clinic, Peters House
Thursday, June 24
9:00 A. M. Orthopedic Grand Rounds
12:00 Noon Thoracic Clinic
Friday, June 25
11:00 A. M. Pediatric Grand Rounds
11:00 A. M. Fracture Grand Rounds
11:30 A. M. Heart Conference
Saturday, June 26
9:00 A. M. Neurological Grand Rounds
10:00 A. M. Medical Conference
Monday, June 28
10:00 A. M. I Surgical Grand Rounds
4:30 P. M. Thoracic Clinic
Tuesday, June 29
10:00 A. M. II Surgical Grand Rounds
Wednesday, June 30
10:00 A. M. Tumor Clinic
12:00 Noon Skin Clinic, Peters House

Dr. Wilfred Hood, of Brighton, Mass., who interned at the R. I. H. from April 15, 1935, to May 1, 1937, left for his home on May 3, 1937, expecting to return to Providence on June 1st to interne at the Lying-In Hospital for a period of six months.

Dr. James P. McCaffrey's internship at the R. I. H. started May 15th. Dr. McCaffrey, whose home is in Providence, attended Harvard College 1929-33 and Tufts Medical 1933-37.

Dr. R. Frederick Nuessle, who has been connected with the State Hospital at Howard since he left the R. I. H., has gone to his home in Bismarck, North Dakota, and taken up residence at a surgical clinic in that city.

On May 10th, Dr. Reeve H. Betts, former intern at the R. I. H. and now of the Lahey Clinic, Boston, gave an interesting talk, illustrated by colored moving pictures, on Thoracic Surgery, before the members of the New England branch of the American Nursing Association. Several nurses from the R. I. H. attended.

Dr. S. Forest Martin has just recovered from an attack of scarlet fever. He is back on duty at the Massachusetts Eye and Ear Infirmary.

Dr. William Lessel Leet, former Night Superintendent of R. I. H., was the guest speaker at the Teachers' Association in Cranston the night of May 19th. Dr. Leet's subject was "The Right Way to Weigh Right."

St. Joseph's Hospital

The monthly Staff Meeting of St. Joseph's Hospital was held on May 13 at 12 o'clock noon. Paper: "Circulatory Disturbances of the Extremities" was presented by Dr. Henry H. Faxon of Boston. Dr. Faxon, who is one of the active members of the Massachusetts General Hospital Staff and is associated with the group studying Circulatory Diseases, presented a very enlightening discourse based upon a large series of cases which have been treated at the Massachusetts General Hospital. He spoke extensively on the treatment of varicosities of the lower extremities. His remarks depicted well what advances can be made when particular lesions are taken over for study, as was done in this particular instance. Undoubtedly many of our Staff were surprised to learn that the findings of this group study showed that the general practice in the treatment of these cases in this locality is far from satisfactory. Many remarked at the surprising information they had gained through this lecture and were very commendatory of the manner in which Dr. Faxon presented the problem.

The marriage of Dr. John A. Gormly, 187 Academy Avenue, Providence, to Miss Helen Johnston, formerly of the Record Office of the Rhode Island Hospital, took place on May 20.

The Annual Outing and Dinner of Saint Joseph's Hospital Staff Association will be held on Wednesday, June 16, at the Metacomet Club, at 1 o'clock. Refreshments will be served at the Club for those arriving during the afternoon. The afternoon will be devoted to open field and the evening to dinner and entertainment. Those who desire to participate in the golf tournament are requested to communicate with either Dr. Richard F. McCoart or Dr. Francis D. O'Connell. It is earnestly hoped that there will be a large attendance at this outing.

Memorial Hospital

There is a new internes' library and reading room in the process of construction. Plans are being made for a complete new X-ray Department with new equipment. Changes are also contemplated in the surgical operating corridor.

Dr. and Mrs. John H. O'Brien announced the birth of a daughter on April 4, 1937.

Dr. Edward H. McCaughey was married April 5, 1937, to Miss Christine Norton.

Dr. Francis C. Kennedy was married on May 20, 1937, to Miss Kathryn Heston of Central Falls.

Dr. F. V. Hussey has recently returned from vacationing in Bermuda.

Four of the internes are leaving the Memorial Hospital June first.

Dr. James E. Fell will spend from June 5 to August 30 at the State Infirmary at Howard. Starting September 1, 1937, he will begin a one year's residency at Carney Hospital, Boston.

Dr. Harold E. Epling intends to take a postgraduate course for two weeks at the New York Tonsil Clinic. Following this he will begin private practice at Pittsfield, New Hampshire.

On June 1, Dr. Calvin B. Chamberlain will take the first part of the National Board examinations. Beginning July 1, he will start a year's work as a district physician at the Boston Dispensary.

After completing his State Board examinations, Dr. John B. Curtis will start his private practice at Lincoln, Rhode Island.

Charles V. Chapin Hospital

Francis A. DeCesare, M.D., who commenced an internship December 1, 1936, was off duty six weeks because of illness but is now back on service and will finish his appointment on June 30. He is a graduate of Providence College and the University of Naples, in Italy.

Edward V. Heffernan, M.D., served an internship of six months here, leaving March 31, 1937, to accept an appointment at the Truesdale Hospital in Fall River. Dr. Heffernan graduated from Georgetown Medical School in 1935. He was at the Mercy Hospital in Springfield, Massachusetts, before coming here. He is a graduate of LaSalle Academy and Providence College.

Herman B. Marks, M.D., completed a six-month service on March 31. He attended Brown University and Tufts College Medical School, graduating from the latter in June, 1934. Before coming to the Charles V. Chapin Hospital, he served an appointment of one year at the William W. Backus Hospital, Norwich, Connecticut. He is opening an office in Pawtucket for the practice of pediatrics.

Vincent G. Tosti, M.D., who was graduated from the Long Island College of Medicine in 1933 and had served two years at the Mary Immaculate Hospital in Jamaica, Brooklyn, came here January first. On April first he returned to become a resident in pediatrics at the Long Island College Hospital for one year, following which he plans to practice pediatrics in Brooklyn, New York.

On the first of April, Bernard N. Gagnon, M.D., another graduate of the Long Island College of Medicine (1935), started a three-month service. He was previously instructor in bacteriology for four years at that institution and has been interning at the Long Island College Hospital for the past two years. Upon leaving here in June, he is going into private practice, probably in Portland, Maine, his home state.

Alfred Conte, M.D., of this city, a graduate of Georgetown University Medical School (1934), commenced a six-month appointment here on April first. He had previously served two years at St. Joseph's Hospital, this city, and three months at the State Sanatorium, Wallum Lake.

George A. Hyder, M.D., of Lawrence, Massachusetts, also started an internship at the Charles V. Chapin Hospital on April 1. He was graduated from Tufts College Medical School this year.

STRONGYLOIDES STERCORALIS

LAURENCE A. SENSEMAN, M.D.

A CASE REPORT FROM THE MEMORIAL HOSPITAL. THROUGH THE COURTESY OF DR. JOHN F. KENNEY, CHIEF OF THE MEDICAL SERVICE, AND DR. CHARLES H. HOLT, CHIEF OF THE SURGICAL SERVICE

No. 40391 (M.H.) Age: 19, Female, Single. Admitted 1/22/37. On Surgical Service.
Transferred to Medical Service on 2/10/37.
Discharged: 2/22/37.

HISTORY:

Chief Complaint: Pain in abdomen—4 days.

Present Illness: Patient has been having sharp abdominal pains off and on for the past four days. They have been localized to the right lower quadrant. Associated with pain, patient has been nauseated but did not vomit and has lost her appetite. It did not keep her from her work, however. On admittance, patient had one degree temperature and slightly increased pulse; 9800 W.B.C. Polys. 61. Lymph. 27. Eosinophiles 12.

Past History: Mumps at 5 years. T. & A. at 7 years of age. No other serious illnesses. Patient states that she has noticed an urticarial rash on the face about 3 times, the last being just two days before Christmas.

Family History: Mother and father living and well. 4 other children in family. One sister, appendectomy here in August. No diathesis.

Systemic History: Negative.

Physical Examination: Well nourished and developed white female adult, lying quietly in bed, does not look very sick, but complaining of pain in the right lower quadrant associated with some nausea.

Abdomen: There is definite tenderness in the right lower quadrant and a slight degree of muscle spasm. No rigidity. Some referred rebound tenderness. There is a small palpable mass in the lower right quadrant which was movable—this, however, disappeared following an enema. No palpable viscera.

Remainder of physical examination was entirely negative.

Diagnosis: Subacute appendicitis intestinal parasites (?).

Note: On finding eosinophilia patient questioned about diet. Has eaten quite a bit of fresh meats; not much pork, however. Has had no muscle pains.

Blood Work:

	Hgb.	R.B.C.	W.B.C.	Poly.	Lymph.	Eosin.	L.M.	Baso.
1/21	90		9,800	61	27	**12**		
1/22	93	4,550,000	8,750	48	34	**16**	2	
2/8			9,400	38	50	**10**		2
3/4			8,600	58	30	**9**	2	1

Urine: Essentially negative.

Feces:

1/25—Strongyloides stercoralis, motile, rhabditiform parasites found and identified in the stool. These are about 250 microns in length.

These were found consistently in the feces on multiple stool examinations.

2/11—The stools of seven members of the family were examined and found negative.

2/19—Gentian violet therapy began.

2/20—There were 10 to 12 motile parasites per preparation present.

2/22—Dead worms were found on the second day.

2/23—Two motile worms found.

Since this date and until the present date the stool specimens show a great diminution in the number of worms found and these are non-motile. It is necessary to do more than one preparation to find any at all.

3/8—No parasites found.

Progress Notes:

1/25/37—Examination of the anus shows no signs of irritation or worms, especially pin worms. There is, however, a small depression at about 6 o'clock of no importance at present. Still complains of pain in the lower right quadrant. Temp. 99. P. 90. R. 20.

1/28/37—Patient operated on this morning. Chronic appendix removed which was immediately opened and taken to the laboratory where motile rhabditiform parasites identical to those found in the stool were present.

1/31/37—General condition is good. Temp. 100.

2/12/37—Patient transferred to the medical service, following uneventful surgical convalescence.

2/15/37—Condition the same.

2/19/37—Gentian violet ½ gr. 1 t. i. d. Vomiting with first administration of tablet; none since.

2/22/37—Discharged to continue gentian violet at home and bring in daily stool specimen. Patient has had no further symptoms or complaints since the operation.

The Fifth International Congress of Radiology will convene at the Palmer House, Chicago, September 13 to 17, 1937. More than 250 scientific papers will be read at the five-day meeting. These will be delivered in each lecturer's own language and will be automatically flashed on screens in English, German and French as the papers are read. What will probably be the greatest scientific and technical exhibit in the history of a radiological congress will be assembled by physicians, physicists and manufacturers of such equipment in conjunction with the congress. The general secretary of the congress is Dr. Benjamin H. Orndoff, 2561 North Clark Street, Chicago.

OBITUARY

CHARLES F. DEACON, M.D.

Charles Frederick Deacon was born in Providence May 13, 1874, and died February 24, 1937. He was born of English parents and was the youngest of three children. He attended the Benefit Street Primary School and a Pawtucket grammar school and high school. He was graduated from Brown University in the class of 1896 and from Harvard Medical School in 1900, and immediately on graduation started practice on Friendship Street, where he continued to the time of his death. He was a member of the Providence Medical Association, the Rhode Island Medical Society and the American Medical Association.

For the past nineteen years he had served the Providence Medical Association as Treasurer. For many years he was surgeon of the Providence Fire Department. He was examiner for several life insurance companies. He was a 32nd degree Mason. The death of his wife, Grace Hazard, in 1932, was a shattering blow to him who treasured so much her guidance and companionship.

He was modest, retiring, self-effacing, seldom speaking on the floor at our Association meetings. He kept abreast of medical progress, his ambition being to incorporate in his practice the tested developments in scientific medicine. He had a large and lucrative practice, being versed, too, in the art of his profession, as the affection of his grateful patients attests. To a small group of his intimates he was a delightful companion and a faithful friend.

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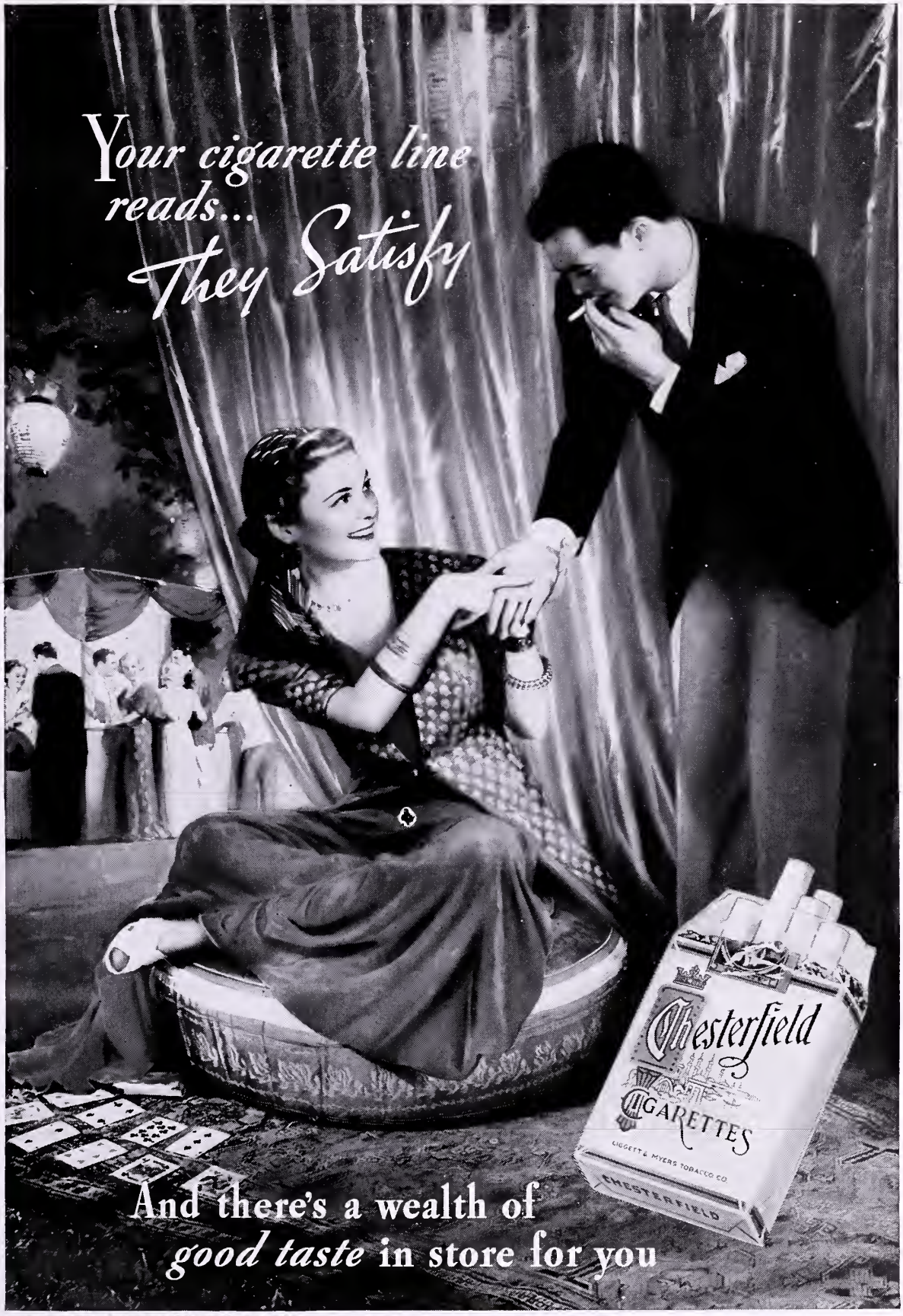
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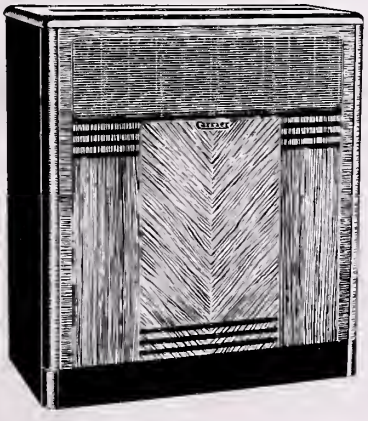
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Minutes of the One-hundred and twenty-sixth Annual Meeting

Officers and Fellows of Washington County and Woonsocket District Medical Societies on Page XII

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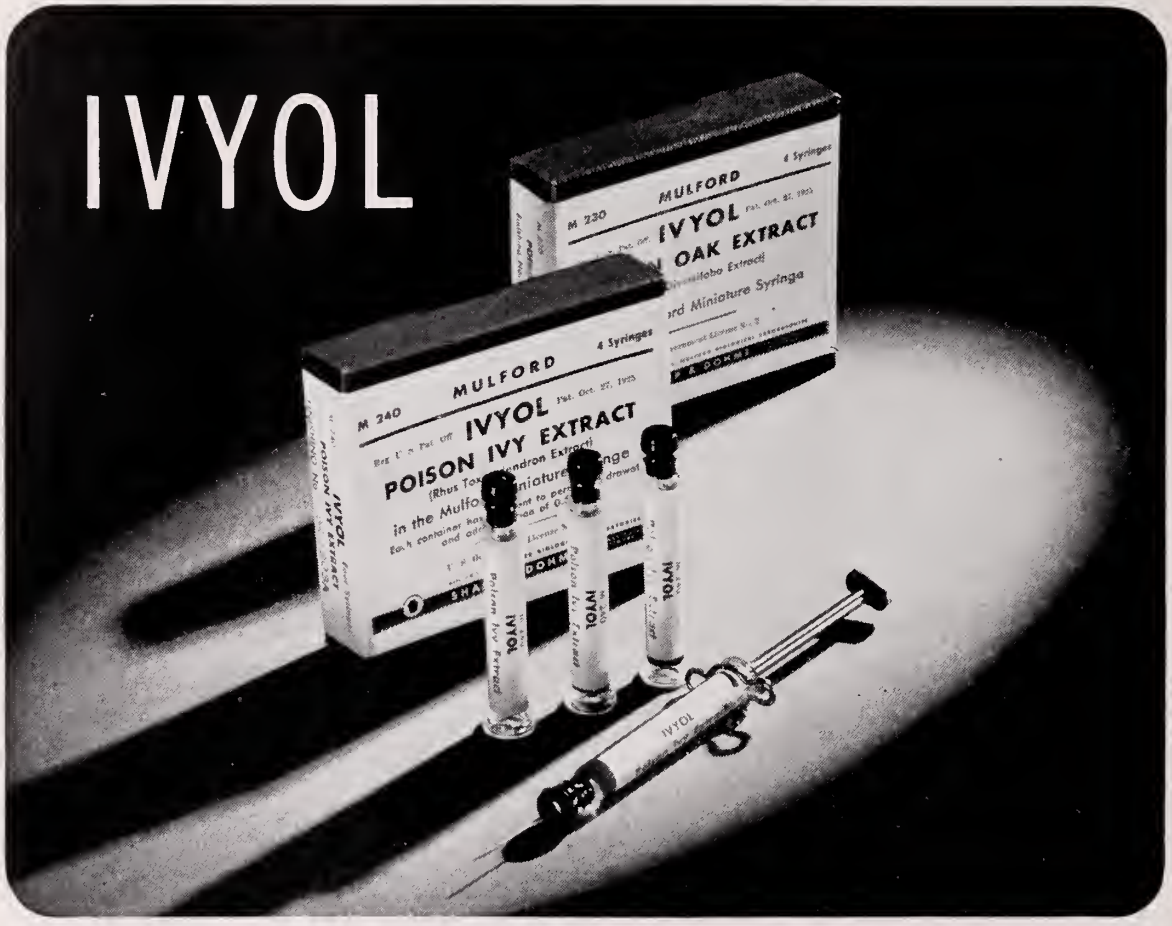
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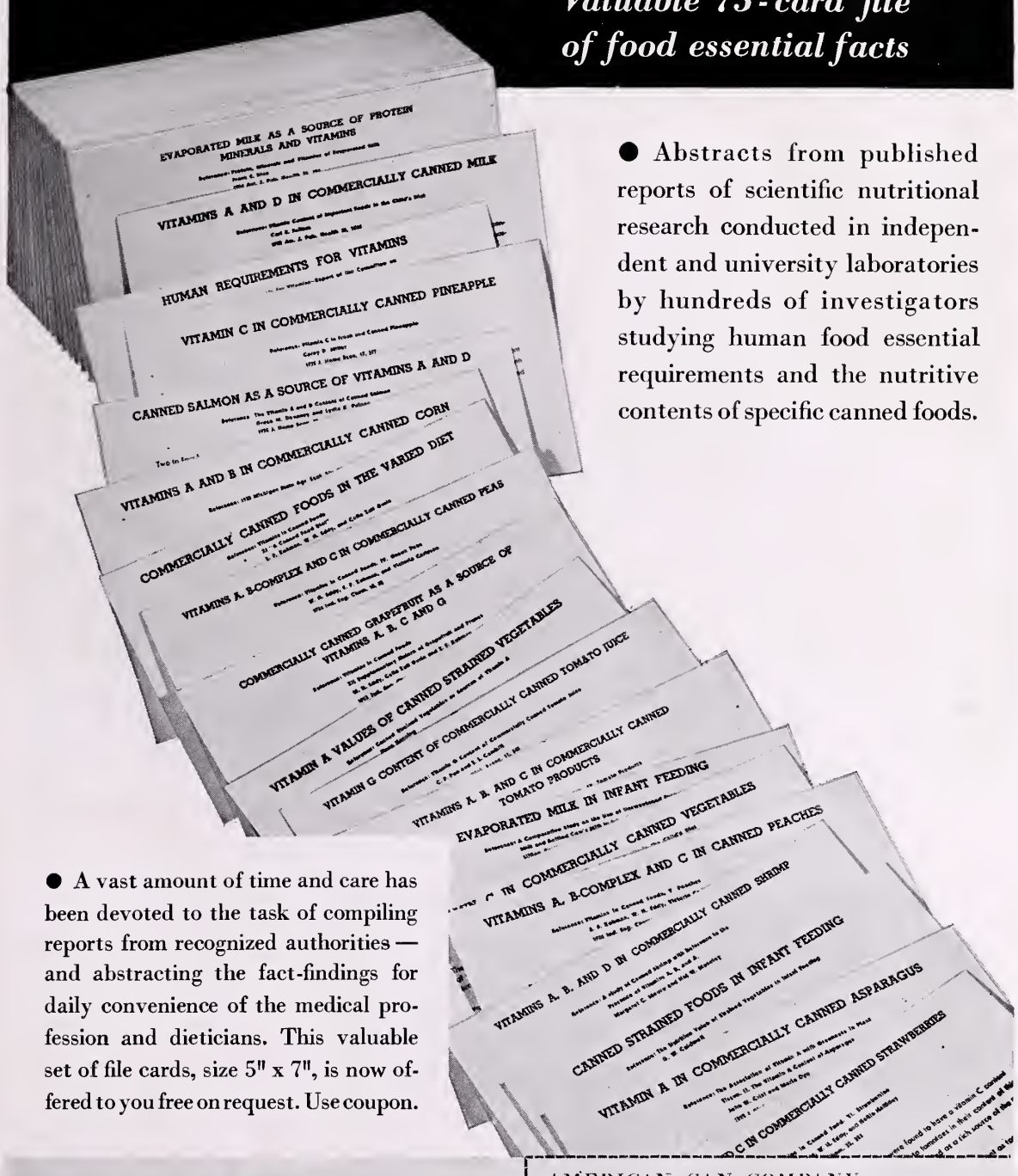
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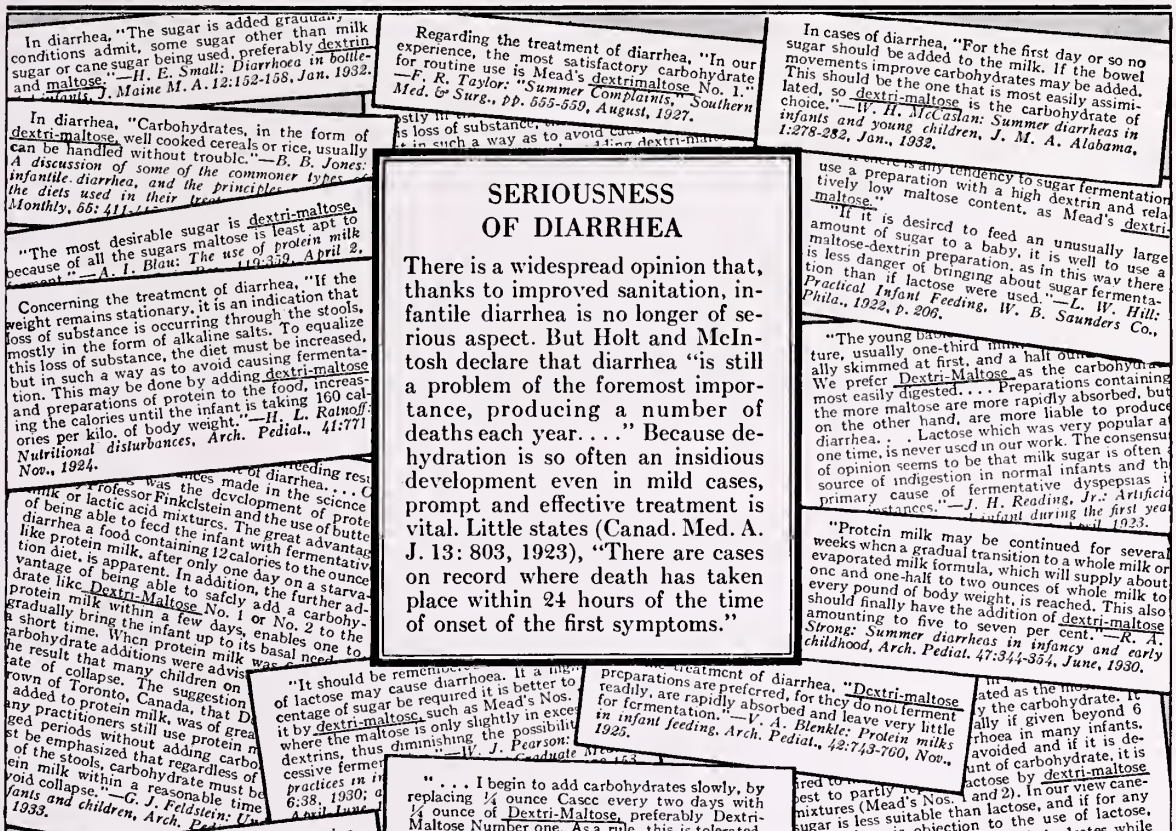
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THE RHODE ISLAND MEDICAL JOURNAL

Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 7 | Whole No. 334 | JULY, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

Annual Address of the President

RHODE ISLAND MEDICAL SOCIETY

June 3, 1937

THE RHODE ISLAND MEDICAL SOCIETY LIBRARY, AFTER TWENTY-FIVE YEARS

JOHN E. DONLEY, M.D.

"The centennial celebration of the Rhode Island Medical Society occupied two days, June 12 and 13, 1912. On the evening of June 12, more than 400 persons, among whom were many prominent state and city officials, officers of Brown University, and leaders in many charitable organizations, were present at the informal reception with which the Society opened its new library on Francis Street. The reception was a brilliant affair, and gave the public its first opportunity to admire the handsome interior of the new structure. Simplicity is a distinguishing feature of the entire building, but it is of a kind that lacks extreme severity, and was relieved at the opening by banks of palms and bouquets on tables in all of the rooms." In these words, Dr. Stephen A. Welch, who was then secretary of the Society, described the opening of this building twenty-five years ago. There are present here today many who will recall the occasion, but there are also many others whose memories do not carry them back so far, and to all of these I would speak this afternoon. For the older Fellows amongst us I would revive pleasant recollections; in the minds of the younger I would arouse a lively appreciation of their precious heritage. For myself, as in private duty bound, I would avail myself of the opportunity afforded by my present office to pay my small tribute of gratitude to our library which, through all those years, has been to me, as Italy was to Linacre, *alma mater studiorum*.

This library of ours, housed in its dignified building, rich in books, pamphlets and journals, binds us to our brethren; not to those only who are with us no more, Rogers, Davenport, Noyes, Miller, Day, Hersey, Keefe, Leech, but also to those others who are still happily in our midst, Blumer, Peters, DeWolf, Mowry, to whose perennial efforts on our behalf we owe a debt which we can pay only with heartfelt gratitude. We, who like to call ourselves younger men, enjoy with small cost to ourselves the fruits of their labors which have helped, in some fashion at least, to make us what we are. It is they who planned and built this library and made it possible for us to enjoy its inestimable advantages. Our forefathers throughout the centuries wrote books, and so many of them did the Society accumulate that it became necessary to build a home to contain them. And so I should like my first words to be those of thankfulness to our Fellows, living and dead, who have made for us so many things possible.

As, day by day, we enter these pleasant rooms, leaving outside awhile the distractions and the annoyances of our busy lives, are we not proud to realize that we hold membership in a profession so ancient, so honorable, so devoted to those standards which have always embodied the eternal values? Opening our minds to the spirit of this place, perhaps we take down from its shelf a volume of Hippocrates or Galen or Vesalius or Pare or Harvey, and while we turn reverently the ageing pages, are we not of one mind with Milton when he writes, "Books are not absolutely dead things, but do contain a potency of life in them to be as active as that soul whose progeny they are; nay, they do preserve as in a vial the purest efficacy and extraction of that living intellect that bred them." It matters little that we can not, most of us, read the Greek or the Latin in which these books are written; merely to stand silently before the works of great men is itself to receive their benediction and to partake of their ennobling influence.

Many of our books are old, tinctured with the spirit and savor of the past, teaching us the lesson of how slow in gestation is the mother of truth, how hazardous the generation, how difficult the propagation of new and fruitful ideas. And why do we reverence old books? Because, as Oliver Wendell Holmes remarked, "There is true pleas-

ure in reading the accounts of great discoveries in the own words of the author. I do not pretend to hoist up the Bibliotheca Anatomica of Magnetus and spread it on my table *every day*. I do not get out my great Albinus before every lecture on the muscles or disturb the majestic repose of Vesalius every time I speak of the bones he has so admirably described and figured; but it does please me to read the first descriptions of parts to which the names of their discoverers have become so joined that not even modern science can part them; to listen to the talk of my old volume as Willis describes his circle, and Fallopius his aqueduct, and Varolius his bridge, and Eustachius his tube, and Munro his foramen. I am not content until I know in what language Harvey announced his discovery of the circulation, and how Spigelius made the liver his perpetual memorial, and Malpighi found a monument more enduring than brass in the corpuscles of the spleen and the kidney.

"There are practical books among these ancient volumes which can never grow old. Would you know how to recognize a 'male hysteria' and to treat it?—take down your Sydenham. Would you read the experience of a physician who was himself the subject of asthma and who, in the words of Dr. Johnson, 'panted on till ninety?'—you will find it in the venerable treatise of Sir John Flower. Would you listen to the story of the King's Evil cured by the royal touch?—go to Wiseman. Would you get at first hand the description of the spinal diseases — which long bore his name? — go to Percival Pott, the great surgeon of the eighteenth century."

Although Dr. Hersey and after him Dr. Blumer, Dr. Day, and Dr. Partridge have written the story of our library, surely it can not be amiss, after twenty-five years and before this audience, to tell it briefly once again for thus shall we keep vigorous and render secure the continuity of our traditions. By knowing something of our history and reflecting upon it, we enrich our souls, because "without history a man's soul is purblind, seeing only the things which almost touch his eyes." (Fuller, *Holy and Profane State*, 1642.) Our young men especially, who are making such fruitful use of this library, should know whence and from whom they have derived their riches.

During the first fifty years of the Society's existence the nucleus of a small library was collected, largely the medical books of deceased members. You will recall that at the first election of officers of our society in 1812 a librarian was chosen, proof that our founding fathers expected that physicians should be interested in books. But the librarian made no annual report, asked for no appropriation, and since the office seemed to involve no duties, it was finally discontinued. In 1859 Dr. Usher Parsons offered a motion, which was carried, calling attention to the need of a room for the Society's books and manuscripts and for holding its meetings. A committee was appointed and, reporting lack of success, was continued for a year and then discharged. The Society held its meetings, now in one place, now in another, until the opening of the Rhode Island Hospital in 1868, after which it met for several years in the old hospital library. To the keeping of the hospital were entrusted the books presented to the Society by Dr. Caleb Fiske in 1835. The Society continued to grow, and in 1874 began again its wanderings and held its meetings in such places as Lyceum Hall, Barney's Hall, the Y.M.C.A., and the Masonic Temple. As late as the 99th annual meeting held on May 31, 1910, the Society was indulging its peripatetic proclivities. Let me quote what Dr. Eugene Kingman remarked in his presidential address on that occasion. "We have two great needs," he said, "first a home; second, money. We have no home. For ninety-eight years we have wandered from place to place, hiring whatever hall we could get. We have met today, May 31, because we could not obtain this hall (Masonic Temple) or one suitable on the regular day of our June meeting. Besides a hall we need a place for our library. We have several thousand books and several complete and valuable files of journals. The Providence Public Library has kindly accommodated us for some time, but now it is crowded, and unless we go to some expense we must leave there. Our Building Committee has a fund in its possession. The rent which we now pay annually for halls and the rent we soon will have to pay for library facilities, if added to the amount we might receive from others for the use of our hall, would make a sum sufficient to pay the interest on a mortgage of fair size. Let us then make it our earnest purpose to procure at once a building appropriate for our use."

In 1876, Dr. Timothy Newell, then the Society's treasurer, drew attention to the urgent need of a permanent depository for its books, pamphlets,

and records, as well as for a place for its meetings. Two years later a committee, of which Dr. Charles O'Leary was chairman, was chosen to report upon the feasibility of founding a library. Dr. O'Leary reported at the December meeting of 1878 that the Society had in its possession 130 books, and that should a library be started and a well-qualified committee and librarian be appointed, the library would certainly grow and become a valuable acquisition for the medical profession of the state. As a result of this report the first annual library committee was chosen at the next annual meeting, June 1879. The members of the committee were Drs. Timothy Newell, Horace G. Miller, W. E. Anthony, George D. Hersey, and Oliver C. Wiggin. Dr. Anthony was elected librarian, but he soon asked to be relieved, and in January, 1880, the committee elected as his successor Dr. George D. Hersey, to whom we owe an everlasting debt of gratitude for his loyal and untiring labors in the building of our present library. He increased the number of our books by increments of 500 to 1500 volumes yearly until it had reached at least 30,000 bound volumes.

In mentioning the name of Dr. Hersey, I am recalling the services of one of our greatest benefactors. For more than thirty years he labored to enrich the library, and with what success we all can observe for ourselves. Is he not worthy of some lasting token of our esteem and gratitude? William Osler's name is associated with the Hall of the Medical and Chirurgical Faculty of Maryland, Oliver Wendell Holmes' with the Boston Medical Library, David Hosack's with the Academy of Medicine in New York, Weir Mitchell's with the College of Physicians in Philadelphia. Why not George D. Hersey's with our own Medical library? It would be a gracious thing to honor him by naming, let us say, our reading room or our assembly hall in his memory. I should like to make this recommendation to the Society as being worthy of serious consideration.

For many years the books were kept in the rooms of the old Franklin Society, until in 1900 the space became inadequate, whereupon they were removed to the third floor of the Providence Public Library, where they reposed until they were brought to this building.

After the removal of the books to the Public Library, the Society's meetings were held either in Rhode Island Hall of Brown University, the Eloise, the Masonic Temple about which you heard Dr. Kingman complain, or in the Young Men's Christian Association Hall.

The corner-stone of this building was laid on June 1, 1911. Dr. Frank L. Day, for the Trustees of the Rhode Island Medical Society Building, presided. Right Reverend James DeWolf Perry, Jr., opened the exercises with prayer. Governor Pothier, Mayor Fletcher of Providence, Mr. H. L. Koopman of the John Hay Library, and Dr. F. C. Shattuck of Boston offered their felicitations. Dr. John M. Peters, chairman of the sub-committee on construction, prepared a box which was placed within the corner-stone. Within the box were the following items: First number, Transactions Rhode Island Medical Society; last number, Transactions Rhode Island Medical Society; list of Fellows, June 1, 1911, Rhode Island Medical Society; Charter, Constitution and By-Laws, Rhode Island Medical Society; Providence Medical Journal, May 1911; Monthly Bulletin for January 1911, of Rhode Island State Board of Health; reports of Rhode Island Hospital, 1910; St. Joseph's Hospital, 1910; Newport Hospital, 1910; Memorial Hospital, Pawtucket; Woonsocket Hospital, Butler Hospital, 1910; Providence Lying-In Hospital, 1910; roster of Providence City Hospital; Providence Journal, Evening Bulletin, Providence Tribune, Providence News, June 1, 1911; coins of date 1911; program of the meeting. Right Reverend Monsignor Thomas F. Doran closed the exercises with benediction.

The Annual Address was delivered by Dr. G. Alder Blumer and was entitled "A Plea for the Medical Library." Dr. Blumer concluded his address with these prophetic words, "The motto of the ancient town in which your speaker first saw the light, once the home of the Venerable Bede, earliest of librarians, is 'Nil desperandum auspice Deo'—incentive words which, on this auspicious anniversary, may well carry to us, across the centuries and athwart the waters, an inspiration to high emprise. Let us then march breast forward to witness the ceremonies that shall now usher in a new era for this honorable Society, sensible that many generations of men yet unborn will read, on enduring walls soon to spring from that corner-stone, the proud legend of their foundation and, so reading, murmur gratitude for their goodly heritage long after we whose pulses beat and are stirred on this memorable day shall have drifted like broken clouds into the Great Beyond of the infinite."

The one-hundred and first annual meeting and the first session to be held in the new building occurred on Thursday, June 13, 1912, in Assembly Hall, Rhode Island Medical Society Library Building. The President, Dr. F. T. Rogers, presided. The Centennial oration was delivered by the venerable Dr. Abraham Jacobi, who spoke on "The Educational Value of Medical Societies and Libraries." In delivering the keys and turning over the new building to the Society, through the incoming President, Dr. Alexander B. Briggs, Dr. Rogers said, "I can not express to you the thoughts that come to my mind, nor in words tell you how highly I esteem the honor which for a brief period is mine, as today we begin a new century of medical life with the dreams of our forefathers and the hopes of many years of waiting realized in this new and magnificent edifice devoted to the medical profession of this state, a home for this Society forevermore, and a permanent housing for its valuable library." And in similar vein, Dr. John M. Peters, handing over to the new President the trowel with which the first mortar was placed in laying the corner-stone, remarked, "May I, who have been in close touch with the progress of the work, express my own appreciation of the tremendous amount of energy and time put into this work by our President and Treasurer. It has been said many times during these first eighteen months that the Society would be without a home of its own for another hundred years were it not for the initiative (without the referendum) of Dr. Rogers. Gentlemen, with him in the lead, with the rest of us helping him along and with the generous gifts of some of our friends, we have succeeded in founding a permanent home that will mean much to us in our work and will add dignity to us in the medical profession.

"We trust that our present members and our successors will find this what it was planned to be, a permanent home, well located, well built and arranged for the convenience and comfort of the Fellows."

Such then, in summary view, is the story of our Society's building and library. For twenty-five years we have held our meetings here; within the walls of this building our members have come to know one another better, making new friends and cementing the ties which bind us to old ones; here on former occasions, as also today, we have welcomed our medical colleagues from other States, bearing their gifts of knowledge and friendship; surrounded by our books we have become, I am sure, more worthy members of our profession and have learned to appreciate, intimately and personally, that noble saying of Hippocrates that where there is love of humanity there also is love of our art.

A library is obviously a great and essential factor in the preservation of knowledge and history. But, as Sir Humphry Rolleston remarked not long ago, it has been rather pessimistically said that a library is a mausoleum where knowledge lies dead and mummified; and this may be a real danger unless it is activated and kept alive by a guide to its contents. A library is not complete without a good catalogue, namely one with the double entry of author and subject; and it is obvious also that the larger the library, the more fully will such a catalogue afford access to existing knowledge, especially when printed and distributed widely to other libraries. For many years our own library lacked a catalogue and was, therefore, more or less useless for those who would consult it. Recently, however, we have begun to realize our hope so long deferred, and I am happy to note that the Library Committee reports that our 30,000 books and journals are in process of being catalogued. This is time-consuming work, and it is good to know that to date our index cards number 21,648, classified under subjects and authors.

When he was a young medical student at the Harvard Medical School, Dr. James H. Davenport, stimulated by the precept and the example of Dr. Oliver Wendell Holmes, his revered teacher, began collecting the extra-professional writings of physicians. Over a period of many years Dr. Davenport assembled these books assiduously and presented them, more than twelve hundred in number, to the Rhode Island Medical Society. It is interesting to remember that, with loving care, he arranged them upon our shelves. You may observe them in the Miller Room,—a collection unique in this country. Here, awaiting our reading in leisure hours, are volumes of fiction, essays, poetry, history, travel, autobiography, memoirs of celebrated physicians, biographies of men who have honored themselves and us,—all of them written by Doctors of Medicine, bearing abundant witness to the sound scholarship, the intellectual versatility, the fine taste, and the love of humaner letters which have always characterized the best men of our pro-

fession. Although Dr. Davenport collected many of the writings of those whom he liked to call the "literary Doctors of Medicine," there are still a considerable number of books which, as yet, we do not possess. Every year our colleagues are publishing books which should find their place in the Davenport Collection. Assuredly it would be a splendid thing to procure as many of these volumes as our means may permit, and I should like to offer his suggestions to our Library Committee. In addition to purchased books it would be pleasant to receive gifts from our Fellows, for there is, I suppose, no way more fitting to honor the memory of Dr. Davenport and to show our own interest in our library than by the presentation of books whereby we may increase the value and add to the completeness of this unusual collection.

If time permitted, how many interesting stories might be told about the books, pamphlets, and journals on the shelves of our library! Within the walls of this building one can enjoy, as often as he may wish, adventures which would gladden the heart of any lover of books. From Hippocrates to the latest volume issued from the press, the whole history of medicine lies open to his view. Perhaps you will allow me to relate one or two of my own experiences which can be duplicated by anyone who cares to do so. Some years ago I took from the shelves in the Miller Room a pamphlet entitled "Discourse upon the Institution of Medical Schools in America," by Dr. John Morgan of Philadelphia. Reading the yellowed pages of Morgan's discourse I was present at the very foundation of higher medical education in our country; for here was a young physician schooled in all the learning of Europe, who in 1765 lighted the Greek torch in the first medical school to be founded in the colonies of America. Morgan received his degree of Doctor of Medicine in Edinburgh in 1763 and presented as his thesis a dissertation on the *Formation of Pus*. From Edinburgh he journeyed to Paris and thence across the Alps to ancient Padua. You will remember that Shakespeare put into the lips of Lucentio in "The Taming of the Shrew," the words:

> "Since for the great desire I had
> To see fair Padua, nursery of arts,
> I am arrived for fruitful Lombardy,
> The pleasant garden of great Italy
> . . . for I have Pisa left
> And am to Padua come, as he that leaves
> A shallow plash to plunge him in the deep
> And with satiety seeks to quench his thirst."

While in Padua Dr. Morgan was graciously received by the celebrated Morgagni who had just published his great work *De sedibus et causis morborum*, an inscribed copy of which he presented to the young American. In our library, as you know, there is a beautiful copy in two volumes of the first edition of Morgagni's work. And why do I say that Morgan lighted the torch of Greek medicine in America? Because the stream of the Greek tradition flowed from Salerno to Padua; thence to Leyden, and from Leyden under Boerhaave to Edinburgh, and from Edinburgh under Alexander Munro and William Cullen in the eighteenth century to the great medical schools of the New World —to Philadelphia, Columbia, and Harvard.

In the autumn of 1833, an insignificant newspaper office in Plattsburg, New York, published at the author's expense one thousand copies of a small octavo volume. The book was printed on ordinary paper and was bound in pasteboard covers. It was issued without acclaim and was featured by no advertising or reviews; and yet in 1933 the centenary of the publication of this modest book was celebrated by scientists in many cities of the United States. The book was William Beaumont's *Observations on the Gastric Juice and the Physiology of Digestion*, which laid the corner-stone of American physiology. In many pleasant mornings among our stacks what was my surprise and delight to discover that we are the proud possessors not of one but of eight copies of this rare and most valuable work! Probably no other library in America can boast as many Beaumonts as our own. Dr. Andrew Combe who edited the Edinburgh reprint of Beaumont's work in 1838, has an interesting note which goes to prove that, like so many other pathfinders in science and medicine, Beaumont was not appreciated at his true value. Combe writes that "in proof of Dr. Beaumont's disinterestedness in conducting the inquiry, I may mention that I have learned from private sources that the expenses attending the various series of experiments exceeded in amount £700 Sterling, the whole of which was defrayed by himself, and for repayment of which he was advised to apply to the Congress, on the ground of the public being interested in the promotion of scientific discovery; but although the American Treasury was at the time literally overflowing, the application was refused."

We Rhode Islanders have three good reasons for remembering the famous Bishop Berkeley,—first,

he lived amongst us; second, he fathered an influential system of philosophy; and third, he left us the recipe for tar water. In 1793 there was reprinted in Providence by J. Carter, "An Authentic Narrative of the Success of Tarwater, In curing a great Number and Variety of Distempers; with Remarks. By Thomas Prior, Esq; Carefully Abridged. To which are subjoined, Two Letters from the Author of Siris: Shewing the Medicinal Properties of Tarwater, and the best Manner of Making it."

Here then, was a local testimonial to the surpassing virtues of tar water. I opened the booklet with great expectations but was hardly prepared for the formidable array of disorders set forth in the index, all of them more or less readily curable by the free use of the good Bishop's beverage. I shall not read the list in full, but perhaps you can bear with A, B and C. The distempers which you may relieve with tar water are: ague, asthma, barrenness, bilious fever, bloody-flux, bloody urine, blood from the lungs, boils, bruises, cancer, canker in the mouth, colic, cold, consumption, contraction of the bowels, costiveness, cramp, coughs. One of the sufferers who was relieved of all manner of things by the "wonderful efficacy of that sovereign remedy Tarwater" invokes the Muses thus,

> "Oh learned Berkley! who enough can praise
> Thy gen'rous labor? thy instructive page,
> Our steps directing to this source of health?
> The fair and beauteous pine in vain had shed
> Its precious juice, till thou, with curious search,
> Explor'd its virtuous qualities, and taught
> Mankind the wholesome secret. Thou hast done
> A deed well worthy everlasting fame."

The Bishop has more than all the confidence of his disciples. In a letter which forms the appendix to this small booklet, he writes, "My experiments have been made in various cases, and on many persons; and I make no doubt its virtues will soon be more fully discovered, as Tarwater is now growing into general use, though not without that opposition which usually attends upon novelty. The great objection I find made to this medicine is, that it promises too much. What! say the objectors, do you pretend to a panacea? a thing strange, chimerical, and contrary to the experience and opinion of all mankind! Now, to speak out and give this objection or question a direct answer, I freely own, that I *suspect* Tarwater is a Panacea. I may be mistaken, but it is worth trial; for the chance of so great and general benefit, I am willing to stand the ridicule of proposing it. And as the old philosopher cried aloud, from the house-tops, to his fellow citizens, *educate your children,* so, I confess, if I had a situation high enough, and a voice loud enough, I would cry out to all valetudinarians upon earth, *drink Tarwater."*

And now, gentlemen, I must take leave of the pleasures to be derived from our library; but not before I have thanked both officers and members of the Society for that always loyal support which has made the tenure of my office an inspiring privilege. As in the past, by our united efforts, we have labored with some success to enhance the usefulness and to further the best interests of our profession, so let us go forward to meet the future in unity, peace and concord.

CONTRACT PRACTICE

It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

From the Code of Ethics of the A. M. A.



Walter C. Rocheleau, M.D.
President of the
Rhode Island Medical Society
1937-38

THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

Albert H. Miller, M.D., *Editor*
28 Everett Avenue, Providence, R. I.
Creighton W. Skelton, M.D., *Business Manager*

Associate Editors
William P. Buffum, M.D. John C. Ham, M.D.
Alex. M. Burgess, M.D. Thad. A. Krolicki, M.D.
Francis H. Chafee, M.D. Edward V. Murphy, M.D.
Henri E. Gauthier, M.D. Malford W. Thewlis, M.D.
George L. Young, M.D.

THE ANNUAL MEETING

The one hundred and twenty-sixth Annual Meeting of the Rhode Island Medical Society provides an example to be emulated by its successors. The scientific program was well divided between fellows of the Society and guest speakers. The guest speakers were men of special eminence in their specialties. Discussion of the papers was active and critical. The round table discussion on "Disorders of the Thyroid" was a feature new to this community. Answering the questions propounded by Dr. Frederic V. Hussey, the members of the group, which included both fellows of the Society and guests, informally discussed many of the conditions of thyroid disease—the physiology and pathology; the etiology; the clinical signs and symptoms of hyperthyroidism and of hypothyroidism, the associated signs and symptoms referable to other systems than the thyroid; the laboratory procedures in diagnosis; the treatment, medical, X-ray, surgical. It was deeply regretted that more time was not allotted to this interesting and instructive symposium.

Although confined to a much smaller space than usual, the commercial and scientific exhibits were a constant center of interest. The Committee on Exhibits should seriously consider means for securing a much larger place for this important part of subsequent meetings. The President is to be congratulated on his excellent scientific program; the Committee on Arrangements, on the decorum which characterized the Annual Dinner; the Committee on Clinics, on the harmony with which the clinics were conducted in different hospitals. It was unusual and refreshing to meet hospital executives attending the clinics in other institutions than their own.

THE EDWIN SMITH SURGICAL PAPYRUS

This is a publication of the Oriental Society of Chicago, and is one of the outstanding examples in the history of scholarship. This is the oldest scientific book in the world. The original dates from 3000 B.C. and the present edition is one made in 1600 B.C. from another copy dating from 2600 B.C. It differs from all other manuscripts of the Ancient Near East in its modern scientific approach to surgical problems. All other Egyptian papyri depend on magic both for the diagnosis and the cure of disease. The Smith papyrus approaches the subject from the viewpoint of a modern text book on anatomy. It begins with case histories of injuries to the head, proceeding downward to the neck, shoulders and spine, and ending dramatically in the middle of the forty-eighth case. The various degrees of the severity of the injury are recognized, from a simple scalp wound to a compound comminuted fracture of the skull. The author appreciates cerebral localization and nearly discovered the circulation of the blood. He is willing to render an unfavorable verdict in cases where there is no possibility of recovery. The treatment is rational and consistent with modern thought, and in only one case is there resort to magic.

AN EDITORIAL OF HISTORY

Editorial in Lancet, 10, 726, 1826.

Mr. Rose has lately tied the femoral artery in a case of femoral aneurism. The operation lasted at least half an hour; the delay partly arose from the shortness of the external incision, but chiefly from the incision being made on the *outer side,* a la Ben Travers, of the sartorius muscle. During the operation the external incision was *frequently* enlarged, and *from the haggled manner in which* the dissection was made, *many were the attempts to pass the ligature under the artery before the sheath was laid open.* The patient appeared to suffer great agony during the process of *pioneering,* and exclaimed to Mr. Rose, (who to him seemed more like a *thorn*), "I think both you and I, sir, have had a hard piece of work of it." Extensive inflammation and suppuration occurred in the sac, and throughout the limb, and the patient made a speedy exit from this world, leaving his shattered limb as another *specimen* of splendid explorative *surgery* at St. George's.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the One Hundred and Twenty-sixth Annual Sessions

Meeting of the Council

The regular meeting of the Council of the Rhode Island Medical Society was called to order by the President, Dr. John E. Donley, Thursday, May 20, 1937, at 4:30 P. M.

The report of the Treasurer was read by Dr. Jesse E. Mowry. On motion of Dr. DeWolf, seconded by Dr. Hammond, the report was accepted. Dr. Mowry then read the financial report of the RHODE ISLAND MEDICAL JOURNAL, which was also approved.

On motion of Dr. Mowry, seconded by Dr. Partridge, the dues of Dr. V. L. Raia were rebated and his name placed on the retired list. The resignation of Dr. George M. Lott was accepted. The Treasurer reported that the dues of seven fellows were in arrears for a longer period than is permitted by the By-laws. It was voted that five of these be dropped from fellowship for non-payment of dues, after sixty days' notice, and that further effort be made to collect the amount due from the others.

On motion of Dr. Mowry, seconded by Dr. Gormly, the matter of an additional telephone for the Medical Library was referred to the Standing Committee of the Providence Medical Association.

The Secretary read a letter from the Washington County Medical Society, relating to contract practice. On motion of Dr. Miller, seconded by Dr. Jones, the action of the Washington County Society was approved. There being no further business, the meeting was then adjourned.

Respectfully submitted,

GUY W. WELLS, M.D.,
Secretary.

Meeting of the House of Delegates

The regular meeting of the House of Delegates was called to order by the President, Dr. John E. Donley, May 20, 1937, at 5:20 P. M. Dr. Hammond read the report of the Committee for the Nomination of Officers for the ensuing year. On motion of Dr. Mowry, seconded by Dr. Jones, the report was accepted and the Secretary was empowered to cast an unanimous ballot for the election of the officers nominated.

The Secretary gave the report of the meeting of the Council. The annual report of the Treasurer was read and approved. Dr. H. A. Winckler, Chairman of the Committee on Arrangements, announced that the Annual Dinner of the Rhode Island Medical Society would again be held at the Pomham Club, on Thursday, June the third, at six P. M. On Wednesday, June the second, a collation would be served at the Medical Library between the hours of six and eight P. M. Dr. Joseph C. O'Connell, Anniversary Chairman, announced that we have been fortunate in obtaining as Speaker for the occasion of the Anniversary Dinner, Dr. Alexander Stoddard, Superintendent of Schools of Providence, who would address the meeting on some educational subject.

The reports of the following committees were then read and approved:

Committee on Publication: Dr. Kingman.

Board of Trustees of the R. I. Medical Library Building: Dr. Brackett.

Library Committee: Dr. John G. Walsh.

Committee on Unemployment Relief: Dr. Gormly.

Committee on Exhibits: Dr. Skelton.

Committee on Publicity: Dr. Bradley.

Committee on Legislation: Dr. Harris.

Committee on Public Health Clinics: Dr. Farrell.

Educational Committee: Dr. Bray.

The recommendation of the Committee on Education that the successful popular lectures at the Medical Library be duplicated in other centers of the State, was favorably discussed by Dr. Farrell.

The Secretary read a letter from the Surgeon General, dealing with the control of syphilis. On motion of Dr. Christie, seconded by Dr. Holt, the President was empowered to appoint a committee of three members to advise with local and national public health authorities in regard to the control of syphilis.

On motion by Dr. Skelton, it was voted that the Secretary be instructed to write to the firm of Blanding and Blanding a letter of appreciation for their aid in advertising the Sunday lectures given at the Medical Library under the Committee on Education.

On motion of Dr. Partridge, seconded by Dr. Jones, it was voted that the dues be $10.00 for the ensuing year.

The meeting was adjourned at 6:10 P.M.

Respectfully submitted,

GUY W. WELLS, M.D.,
Secretary.

The Annual Meeting

The one hundred and twenty-sixth Annual Meeting of the Rhode Island Medical Society was held June 2nd and 3rd, 1937. Mornings were devoted to clinical work and afternoons to the reading and discussion of papers.

Wednesday morning, a wide variety of clinics were held in Butler, Pawtucket Memorial and St. Joseph's Hospitals. Thursday morning, clinics were held in Miriam and Rhode Island Hospitals. In order to be of value to the greatest number of the members of the State Society, a variety of subjects were chosen. Besides clinics in general medicine and surgery and the specialties, others were given in X-ray, anesthesia, blood transfusion and by the departments of photography. The clinics as a whole were well attended.

Wednesday afternoon, following the report of the Secretary, an address of welcome was given by His Honor, Mayor James E. Dunne. He complimented the Society on its accomplishment in owning the Medical Library Building, remembered his own participation in the hanging of the picture of Dr. Charles V. Chapin, commented on the interest in our Sunday lectures, and noted the uncompensated service of the profession to the community. In his reply, our President, Dr. John E. Donley, said "The less we have the more we give." The President then welcomed the delegates from other New England state societies. Dr. J. E. Ruisi reported for the Committee on Necrology. Dr. Wilfred Pickles reported that the Trustees of the Fiske Fund had found no essay of sufficient merit to warrant awarding the Fiske Fund Prize. He announced as the topic for the next competition, "Surgical Treatment of Disorders of the Autonomic Nervous System." The Secretary read the report of the Nominating Committee and reported on the election of officers by the House of Delegates.

The afternoon program consisted of four papers, the first, on "Some Practical Aspects of the Diagnosis and Treatment of Pernicious Anemia," was by Dr. Herman A. Lawson. This condition is a definite disease, presumably caused by inability of the body to absorb adequately food materials necessary to maintain a normal supply of red blood cells. The author emphasized the importance of correctly diagnosing and starting to treat the disease in its early stages. As the treatment is prolonged the disease must not be said to be present unless the clinical evidence is convincing, the most important signs being anemia, digestive disturbance, and certain nervous symptoms. Correct laboratory diagnosis by microscopic examination of the blood must always be carried out. A large proportion of the patients must be treated by injection into the muscles of the proper medicine. If treatment is adequate and maintained, the outlook for return to health is very much better than is commonly supposed. Incomplete treatment does not prevent continuation of the disease, which was usually fatal until discovery of its specific cure about 10 years ago.

Dr. William S. Streker, opening the discussion of Dr. Lawson's paper, said in part:—This is a valuable paper because it presents the results of personal experience. Dr. Lawson has taken some of the boys on a trip to the wood shed, magnanimously. My earlier cases were treated on parenteral liver. Liver extract was ordered and given by the nurse. One transfusion was followed by a terrifying reaction. The patient went on to a complete recovery. One developed abscesses at the seat of injection, which required surgical treatment. There is widespread misconception of the central nervous degeneration. Neurological changes may be oedematous. I have seen two cases of mental disturbance; one a mild psychosis, the other delusional. It is important to obtain a reliable liver preparation, as the preparations vary in potency. My personal plan is to attempt liver in some form every day and to give an injection at the office once a month.

Dr. Lawson:—I have no experience with the intravenous injection. I have encountered no mental disturbances. The liver extract can be used intramuscularly at half the cost of the capsules by mouth.

The second paper, by Dr. Jesse P. Eddy, 3rd, was entitled "Experiences with Blood Transfusion at the Memorial Hospital." At the Memorial Hospital in Pawtucket a special service has been provided for over two years, whereby members of the staff may always call upon the services of physicians and their assistants who are specially qualified, to perform blood transfusion when necessary. The giving of one person's blood to another person who is ill is never carried out unless necessary, but by improving the hospital facilities for the procedure, more patients have been able to profit from this form of treatment, and with better results as far as the effects of the transfusion are concerned. A

bureau of blood donors who are readily available has been established in Pawtucket. The American Legion has made it financially possible in certain instances to supply blood to patients who cannot afford the cost. Developments of this sort are most helpful to the community.

Dr. Eddy's paper was illustrated with a motion picture of an actual transfusion. Both of these papers were by members of the Society.

Dr. Francis H. Chafee, opening the discussion of Dr. Eddy's paper, said in part:—Transfusion is not a simple procedure but one to be done by an experienced person. The question of too few or too many transfusions may be referred to the experience with the use of intravenous fluid which has markedly increased in the past ten years.

Dr. Cecil C. Dustin:—Dr. Julius Kelly and I have done five hundred transfusions, 90% by the citrated method, with less than 2% of reactions, none of them serious. The direct method may be the method of choice for a trained team.

Dr. Alex. M. Burgess:—The multiple syringe transfusion should be called not the direct method but the whole blood method. We should keep the citrated method. In comparison with a method which requires an available, expert, trained team, the citrated method is rather simple. Bad results with the whole blood method have occurred in the hands of the inexperienced.

Dr. John F. Kenney:—In Russia, I saw transfusions with blood from a cadaver twenty-four hours old, kept up to a month. Although they have done 1500 such transfusions without a reaction, deliver me from a blood transfusion in Russia.

Dr. A. K. H. Sundin:—The rate of flow is a factor in producing reactions.

Dr. Eddy:—Multiple syringe transfusion is a simple method for an expert with one trained nurse.

The third paper, entitled "Observations on the Mechanisms Producing Shock," was read by Dr. Dana W. Atchley, Assistant Professor of Medicine in the College of Physicians and Surgeons of Columbia University. Shock in the medical sense is sudden vital depression of varying degree, but which may be very serious. It may be a complication of several medical conditions. The author feels that too rigid attempts have been made to catalogue the various forms of shock. Changes in body function resulting in shock were discussed. By an understanding of what actually produces shock, the physician is better able to treat the condition.

Dr. Frank T. Fulton, opening the discussion of Dr. Atchley's paper:—Dr. Atchley has given us such a splendid presentation of his subject that it is difficult to discuss. I would emphasize the disproportion between blood volume and capacity of the bed as the fundamental idea to carry away.

Dr. Alex. M. Burgess:—I raise the question of a small amount of adrenalin with a large amount of saline in shock.

Dr. Fulton:—The diagnosis between cardiac failure and shock may make the difference between life and death to the patient.

Dr. Atchley:—It is a fact that small, continued doses of adrenalin can produce the signs of shock.

The last number of the afternoon program consisted of a round table discussion on "Disorders of the Thyroid," arranged by Dr. Frederic V. Hussey and participated in by Drs. Frank H. Lahey and Lewis M. Hurxthal of Boston, John F. Kenney of Pawtucket, Guy W. Wells, Isaac Gerber and Cecil C. Dustin of Providence. Disorders involving too active function of the thyroid gland, and also disorders involving defective function of this one of the glands of internal secretion were discussed. The physicians presented the viewpoints resulting from various types of specialized experience with these conditions. Recent new and important scientific work has greatly improved the physician's understanding of thyroid disease, and his ability to relieve or cure the patient.

Dr. R. G. Leland of the Bureau of Medical Economics of the American Medical Association addressed the Society in the evening session. Dr. Leland's subject: "Is Medicine to be Socialized?" This was of great interest to the Medical Profession in view of the changes in government at the present time. The Rhode Island Medical Society is especially grateful to him for his paper.

Dr. Leland:—Throughout the past 2,000 years or more, the one tie that has continued to bind physicians closely is the Principles of Medical Ethics. The Principles of Medical Ethics are: that the practice of medicine should be restricted to those specially trained; that competition between physicians should be based on quality of service and not on fees; that successful diagnosis and treatment usually rest on mutual confidence between the patient and his physician; that groups of physicians should neither employ nor demand rules of conduct that are not appropriate for the individual private

practitioner; and that any system of medicine should include all reputable physicians. Sometimes, the medical profession finds itself engulfed by national movements which threaten to destroy many patterns and social values which have required generations to acquire and perfect. A large number of foreign countries have adopted different forms of state managed medicine. In some of these systems there are more bureaucratic employees than physicians giving medical service. The "red tape," records, political interference, domination and control is so great that the physician cannot devote the time he should to the actual practice of medicine. Thus, both quality and quantity of medical care tends to be reduced. We, in the United States, are justified in drawing our own conclusions from the best available facts as to whether these types of state managed medicine are suitable for the United States of America.

The last paper, "Surgical Curiosities and Rareties" with lantern illustrations, was read by Dr. John F. Erdmann, Visiting Surgeon of New York Post Graduate Hospital. Objects and procedures of interest to physicians, rare and curious from the professional and technical viewpoint, were presented by this New York surgeon who is recognized for his achievements throughout the world.

At 2 P. M. on Thursday afternoon, the Society again assembled in the auditorium of the Medical Library Building. The first paper presented was by Dr. Charles W. McClure, Assistant Professor of Gastro-Enterology at Boston University School of Medicine. He spoke on "Affections of the Colon." The author presented X-ray films and photographs illustrating alterations in the structure of this part of the intestinal canal, which were the cause or result of disease. A discussion of disturbances of the functions of the colon in which there were no changes in its structure was also held. Clear understanding of these conditions enables the physician to treat them much more effectively.

Dr. Frank A. Cummings, opening the discussion of Dr. McClure's paper, said that the colon is a center for infections. He emphasized the importance of examination of the stools and of X-ray examination in every case.

Dr. Russell S. Bray held that carcinoma of the sigmoid and diverticulitis can be diagnosed with the X-ray. We should always distinguish colitis from functional disturbances of the colon. An old megacolon may leave secondary changes.

Dr. D. Frank Gray stated that ulcer is often diagnosed as chronic indigestion. Later he found that cholecystitis may produce the same symptoms as ulcer. The liver has much to do with gallbladder symptoms.

Dr. McClure agreed as to the importance of diagnosis between carcinoma and diverticulitis. An exploratory operation may be justified to settle the diagnosis. An atonic colon may resemble a megacolon.

"The Diagnosis and Treatment of Trigeminal Neuralgia and Meniere's Disease" was the title of a paper by Dr. Gilbert Horrax, Director of the Department of Neurosurgery of the Lahey Clinic. The cause of trigeminal neuralgia is not known. It starts as a slight infection, perhaps in the teeth; when developed, extraction of the teeth is without benefit. The attacks of pain are severe but intermittent, lasting only a few seconds. The attacks are brought on by some external stimulus, as a draft of air, or by shaving, chewing or swallowing. It is a disease of later life. Remember that the treatment is of choice rather than of necessity. Treatment of the first attack should be expectant, rest in bed and a sedative. The pain may be made less by inhalations of trichlorethylene, by having a skillful physician inject alcohol into the nerve, or by partial cutting of part of the nerve. This last operation has been greatly simplified, and in the hands of a qualified neurosurgeon is permanently effective and usually without the complication of facial paralysis. Meniere's disease is a disorder of the internal organ of the ear, and among other things causes distress by recurrent dizziness. It may be treated successfully in certain patients by using a low sodium diet with the addition of ammonium chloride—the Fürstenburg diet. Other patients are best treated by partial cutting of the acoustic nerve by a competent neurosurgeon.

Dr. Horrax' paper was illustrated with lantern slides.

The annual address was read by the President, Dr. John E. Donley, with the title "The Rhode Island Medical Library after Twenty-five Years."

Officers for the ensuing year were inducted into office as follows:

President	Dr. Walter C. Rocheleau
First Vice President	Dr. Edward S. Brackett
Second Vice President	Dr. Charles H. Holt
Treasurer	Dr. Jesse E. Mowry
Secretary	Dr. Guy W. Wells

The scientific sessions then adjourned and the members reassembled for the Annual Dinner at the Pomham Club Thursday evening. Dr. Joseph C. O'Connell, Anniversary Chairman, was toastmaster. Dr. Edward A. McLoughlin brought the greetings of His Excellency, Robert E. Quinn, Governor of the State of Rhode Island. Dr. Alexander J. Stoddard, Providence Superintendent of Schools, gave an especially interesting address entitled, "Some High Lights of the American Scene."

Respectfully submitted,
GUY W. WELLS, M.D.,
Secretary.

Report of the Nominating Committee

The Nominating Committee appointed by the President to submit to the House of Delegates a list of officers and standing committees for the ensuing year, begs leave to report as follows:

For President:
Walter C. Rocheleau, Woonsocket
First Vice President:
Edward S. Brackett, Providence
Second Vice President:
Charles H. Holt, Pawtucket
Secretary:
Guy W. Wells, Providence
Treasurer:
Jesse E. Mowry, Providence

Standing Committees

Legislation, State and National:
Herbert E. Harris, Providence
Charles H. Holt, Pawtucket
Charles F. Gormly, Providence
Publication:
Lucius C. Kingman, Providence
Harry C. Messinger, Providence
Charles S. Christie, West Warwick
Education, State and National:
George L. Young, East Greenwich
Jesse P. Eddy, 3d, Providence
Thad A. Krolicki, Pawtucket
Library:
John G. Walsh, Providence
Herbert G. Partridge, Providence
Edward V. Murphy, Newport
Necrology:
H. Lorenzo Emidy, Woonsocket
Clarence H. Woodmansie, Providence
Harry F. Crandall, Westerly
Arrangements:
Robert R. Baldridge, Providence
Frank W. Dimmitt, Providence
Nathan A. Bolotow, Providence
Delegate to the American Medical Association:
Guy W. Wells, Providence
Alternate:
Alex. M. Burgess, Providence
Curator:
Carl D. Sawyer, Providence
Auditor for two years:
Harold L. Collom, Apponaug

Respectfully submitted,
L. H. JOHNSON, M.D.
HENRI E. GAUTHIER, M.D.
WILLIAM S. STREKER, M.D.
JOHN F. KENNEY, M.D.
ROLAND HAMMOND, M.D.

Report of the Treasurer

RECEIPTS

Cash on Hand January 1, 1936	$ 705.23
Annual Dues	4,150.00
Donations	654.75
Harris Fund	181.00
Terry Fund	76.80
Davenport Fund	71.20
Ely Fund	74.00
Morgan Fund	22.50
Exhibits, Annual Meeting	770.00
	$6,705.48

EXPENDITURES

Collation and Annual Dinner Expenses	$1,044.82
Expenses of Secretary (Secretary service, etc.)	134.25
Printing and Postage	185.54
Gas	42.51
Electricity	105.94
Fuel	469.25
Telephone	130.54
City Water	17.09
House Supplies and Expenses	274.08
House Repairs	186.88
Librarian	1,660.00
Janitor	720.00
Journals, Ely and Terry Funds	79.50
Safe Deposit	6.60
Treasurer's Bond	25.00
Dues, Medical Library Association	10.00
Delegate, American Medical Association	100.00
Sunday Lectures	204.16
Exhibits, Expenses	261.87
	$5,658.03
Cash on Hand to Balance	1,047.45
	$6,705.48

STATEMENT OF INVESTED FUNDS

J. W. C. Ely Fund

January 1, 1936		January 1, 1937	
37 shares Rhode Island Public Service Co.	$1,071.67	37 shares Rhode Island Public Service Co.	$1,071.67
Interest	74.00	11⅕ new shares Common Stock, Mechanics Nat. Bk.	280.00
11⅕ new shares Common Stock, Mechanics Nat. Bk. (In place of 8 old shares, Mechanics Nat. Bk. Stock)	280.00	Paid Rhode Island Medical Society for Journals	74.00
Interest in default	.....		
	$1,425.67		$1,425.67

Endowment Fund

January 1, 1936		January 1, 1937	
2,000 Oklahoma Gas & Electric Co. 1st Mort. 5%	$1,920.00	2,000 Oklahoma Gas & Electric Co.	$1,920.00
Interest	100.00		
Peoples Savings Bank	2,901.92	Peoples Savings Bank	3,076.14
Bank interest	74.22		
	$4,996.14		$4,996.14

E. M. Harris Fund

January 1, 1936		January 1, 1937	
2,000 A-NY & B-NY Realizing Corporation Debentures 5½%	$2,000.00	2,000 A-NY & B-NY Realizing Corp. Debentures	$2,000.00
4 shares stock A-NY & B-NY Realizing Corp.	.....	4 shares stock A-NY & B-NY Realizing Corp.	.....
Interest in default	.....	2,000 General Public Utilities	1,980.00
2,000 General Public Utilities Co. 6½%	1,980.00	1,000 Central Arizona Light & Power Co.	962.50
Interest	156.00	Paid R. I. Medical Society for Repairs on Building	181.00
1,000 Central Arizona Light & Power Co. 5%	962.50		
Interest	25.00		
	$5,123.50		$5,123.50

Frank L. Day Fund

January 1, 1936		January 1, 1937	
3,000 Canadian National Railway Co. 4%	$2,979.75	3,000 Canadian National Railway Co.	$2,979.75
Interest	135.00	Paid for Medical Books	154.57
Industrial Trust Company	431.48	Industrial Trust Company	411.91
	$3,546.23		$3,546.23

Herbert Terry Fund

January 1, 1936		January 1, 1937	
96 shares Providence Gas Co.	$1,152.00	96 shares Providence Gas Co.	$1,152.00
Interest	76.80	Paid Rhode Island Medical Society for Journals	29.50
Balance on hand	480.90	Balance on hand	528.20
	$1,709.70		$1,709.70

James R. Morgan Fund

January 1, 1936		January 1, 1937	
500 Missouri Power & Light Co. 4½%	$441.38	500 Missouri Power & Light Co.	$441.38
Interest	22.50	Paid Rhode Island Medical Society for Expenses	22.50
	$463.88		$463.88

James H. Davenport Fund

January 1, 1936		January 1, 1937	
89 shares Providence Gas Co.	$1,068.00	89 shares Providence Gas Co.	$1,068.00
Interest	71.20	Balance on hand	380.73
Balance on hand	309.53		
	$1,448.73		$1,448.73

Cataloguing Fund

January 1, 1936		January 1, 1937	
Peoples Savings Bank, Clinical Conference Fund	$132.59	Expenses for year Jan. 1, 1936-Jan. 1, 1937	$ 45.70
Interest	3.33	Peoples Savings Bank	135.92
Providence National Bank, Checking Account	192.15	Providence National Bank, Checking Account	146.45
	$328.07		$328.07

Participation Account

January 1, 1936		January 1, 1937	
Providence Institution for Savings	$539.90	Providence Institution for Savings	$553.47
Interest	13.57		
	$553.47		$553.47

Examined and found correct, May 17, 1937.

ADOLPH W. ECKSTEIN, M.D.
FRANK B. LITTLEFIELD, M.D., *Auditors.*

Respectfully submitted,

JESSE E. MOWRY, M.D., *Treasurer.*

Report of the Library Committee

The year 1936-1937 has been a busy one at the Library. There were 1,679 visitors and many telephone requests for information on various subjects.

The number of volumes added by gift and purchase was 615 and 118 volumes were bound. About 700 were repaired at the State House by WPA workers.

The total number of cataloguing cards up to the present time is 21,648. The number of books and journals catalogued to date is 8,475. A new typewriter has recently been purchased to help with this work.

The subscription of journals, which has previously been carried on with the different publishers, has been given largely to the Moore-Cottrell Agencies, thus saving many letters and numerous small bills. About 109 journals are currently received.

Respectfully submitted,

JOHN G. WALSH, M.D., *Chairman.*

Report of the Committee on Commercial Exhibits

Seventeen firms engaged twenty-six booths for the Annual Meeting, June 2 and 3, 1937. These booths were located in the Reading Room and at the rear of the upper hall.

Respectfully submitted,

C. W. SKELTON, M.D., *Chairman.*

Report of the Committee on Clinics

The Committee on Hospital Clinics held on June 2 and June 3, 1937, in connection with the Annual Meeting of the Rhode Island Medical Society, submit the following report:

Hospital clinics have been held at eight hospitals in Providence and Pawtucket at the two previous meetings. In 1935 seven clinics and in 1936 eight clinics were held. The attendance the first year was fair while last year it was poor. The committee felt that fewer clinics each year might result in better attendance and more interest in these clinics. This phase of the situation was considered at length and talked over with the representatives of the various hospitals on the committee. It was finally decided to hold five clinics this year as follows: Wednesday, June 2, Butler Hospital, Memorial Hospital, St. Joseph's Hospital; Thursday, June 3, Miriam Hospital, Rhode Island Hospital. All of these hospitals will serve luncheon after the clinics. It is understood that the hospitals not holding clinics this year will do so next year.

Respectfully submitted,

CHARLES O. COOKE, M.D., *Chairman.*

(The Minutes of the 1937 Meeting of the Rhode Island Medical Society to be continued in the August number.)

Personal Notes

JUNE 7-11. Registration at the Atlantic City meeting of the American Medical Association was 9,534. Registered from Rhode Island:

Bowen, Earl A.	Kempker, Adele C.
Bradley, Charles	Leech, Clifton B.
Buxton, Bertram H.	Leet, Wm. Lessel
Castallo, Salvatore	Mankis, George R.
Chapian, M. A.	Matteo, Frank I.
Cicma, H.	McLaughlin, Edward A.
Cohen, William B.	Miller, Albert H.
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Crank, R. P.	Potter, Alfred L.
Cummings, Frank A.	Prior, James H.
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Hughes, William N.	Wittig, Joseph E.

The feature of the meeting was the address of Senator James Hamilton Lewis before the House of Delegates on June 10, well set forth in *Time* for June 21. In the House of Delegates, Dr. Roland Hammond represented the Section on Orthopedics and Dr. Guy W. Wells, the Rhode Island Medical Society. Dr. Samuel Morein discussed a paper in the Section on Gastro-enterology and Proctology. In the concurrent Congress of Anesthetists, Dr. Albert H. Miller read a paper on "The Role of Diaphragmatic Breathing in Anesthesia and a Pneumographic Method of Recording," discussed by Dr. John A. Hayward of Providence and Dr. Cline N. Chipman of Washington, D. C. Drs. Bertram H. Buxton, George W. Waterman, Alfred L. Potter, and John G. Walsh successfully passed the general examinations of the American Board of Obstetrics and Gynecology.

JUNE 16. The annual Outing and Dinner of the Staff Association of St. Joseph's Hospital was held at the Metacomet Golf Club, East Providence. The afternoon was spent in golf and other sports while a continuous buffet lunch was available. Dinner was served at 7:00 P. M. and was followed by an entertainment.

JUNE 24. The fifty-second Annual Meeting of the Rhode Island Medico-Legal Society was held at Hearthstone House, Seekonk, Mass., at 5 P. M. Following the business meeting, a dinner was served.

JUNE 26. The Friday Night and Amos Throop Medical Clubs were entertained by Dr. Halsey DeWolf at his summer home at Ferrycliffe, Bristol.

Rhode Island Hospital

On June 6th, 1937, at the Lying-In Hospital, to Dr. and Mrs. Gayton S. Bailey, a daughter, Bettina Ann. Dr. Bailey is Resident House Physician at the Rhode Island Hospital.

The marriage of Dr. David Freedman to Miss Claire Reizen took place in Providence, on May 17th, 1937.

At the Holy Name Church, Providence, the marriage of Dr. Robert Gordon Murphy to Miss Elizabeth Theresa Walsh took place, on June 19th, 1937.

Dr. Melvin Bernhard's term as Pathological Intern expired on June 15th. Dr. Bernhard returned to his home in Louisville, Kentucky, by airplane. He is to be Chief Resident in Surgery at the Louisville City Hospital. Before coming to the R. I. H. he spent three years as Assistant Resident at that institution. Dr. Bernhard obtained his A.B. and M.D. degrees from the University of Louisville.

Dr. Charles S. Bryan, of Providence, Harvard A. B. and Harvard Medical School 1937, started his internship at the Rhode Island Hospital on June 15th.

Woonsocket Hospital

The regular meeting of the Woonsocket Hospital Staff was held May 10th, 1937, with Dr. T. Frank Kennedy presiding. Dr. Francis J. King read a paper on "The Essentials in a Hospital Approved for Interne Training."

The monthly clinical conference was held May 24th, 1937. The first case, one of "Friedrich's Ataxia," was presented by Dr. H. Lorenzo Emidy. General discussion followed. Dr. Henri E. Gauthier presented a case of malignant perineal tumor of four years' duration. As an exhibit, a transfusion was performed, by the gravity-vacuum method.

OBITUARY

J. EDWARD McCABE, M.D.

Dr. J. Edward McCabe died in St. Joseph's Hospital December 13, 1936, in his fifty-first year. He is mourned by a host of friends and patients.

Dr. McCabe was born in Providence, the son of James J. and Anna McCabe. He removed to North Attleboro with his parents at an early age, and was educated in the schools of that town. He studied medicine at Tufts College Medical School and graduated in 1914. After serving his interneship at St. Joseph's Hospital, he began practice in Providence. He was a First Lieutenant in service during the World War. He was an assistant to Dr. John W. Keefe at the Keefe Surgery from 1916 to 1926; Assistant Surgeon at St. Joseph's Hospital for the same period. At this time his health failed, beginning inroads of cardiorenal vascular disease affecting his sight, and he was forced to relinquish most of his surgical, general and active hospital work.

Dr. McCabe was an associate member of the Staff of St. Joseph's Hospital, the Homeopathic Hospital, past physician to the State Home and School and State Institutions, a fellow of the American Medical Association, the Rhode Island Medical Society and the Providence Medical Association. He was a member of the Metacomet Golf Club, a life member of the North Attleboro lodge of Elks, and of the Knights of Columbus. He loved music, was a skilled pianist and had a good voice. Much of his leisure time was spent at the piano. Athletic in his youth, all outdoor sports appealed to him. His office and residence were at 341 Smith Street. He was unmarried.

He had a pleasing personality, sympathy, ability, training, and a remarkable understanding of human nature and disease. Death ended a successful and promising medical career.

Edward F. Burke, M.D.,
Parker Mills, M.D.

JOSEPH HENRY AKERS, M.D.

Dr. Joseph Henry Akers, one of the senior members of this association, died in Attleboro, Mass., on April 4, 1937. He was born in Granby, Massachusetts, November 11, 1856, the son of Joseph Washington and Lucy Tufts Akers. After preliminary education in the public schools, he entered Dartmouth College Medical School, from which he was graduated with the degree of M.D. in 1884. After post graduate study in New York, he began practice in Fiskdale, Mass., but after a year he removed to Providence, where he engaged in the general practise of medicine, until his retirement in 1935.

Dr. Akers was on the Staff of the Rhode Island Hospital in the Medical Department from 1888 to 1890, and in 1890 became House Physician to the Providence Lying-In Hospital, a position not at that time requiring residence in the Hospital. In 1892 he was elected Visiting Physician to the Hospital, and served until his resignation in 1903. He was then chosen Consulting Physician, which office he held at the time of his death.

He was a member of the Providence Medical Association from 1888 and a Fellow of the Rhode Island Medical Society from the same date.

Dr. Akers was a typical general practitioner of the olden times, having a most extensive practice in general medicine, minor surgery and especially obstetrics, in which he was not only keenly interested, but in which he excelled. He was, as all who were taught by him realized, thoroughly grounded in the theory of obstetrics and also a remarkable clinician. He had a great love for the Lying-In Hospital, and was very generous to the institution in many ways known only to those intimately connected with it. For avocation, he was much devoted to music, and for many years during his most busy times he continued the study of the violin.

He was highly respected by his colleagues in the profession, and was beloved to an unusual degree by his patients.

Charles W. Higgins, M.D.
H. G. Partridge, M.D.

Announcement is made of the 16th annual clinical and scientific session of the American Congress of Physical Therapy, September 20-24, at the Netherland Plaza Hotel, Cincinnati. The program includes many special features: sectional meetings in the specialties, symposia on short wave diathermy, hyperpyrexia, electrosurgery. Fever therapy and the treatment of vascular diseases will be discussed by prominent workers in the field. Other features include technical and scientific exhibits and a full day of hospital clinics where technic will be adequately demonstrated. There will be no registration fee. The executive offices of the Congress are at 30 North Michigan Avenue, Chicago.



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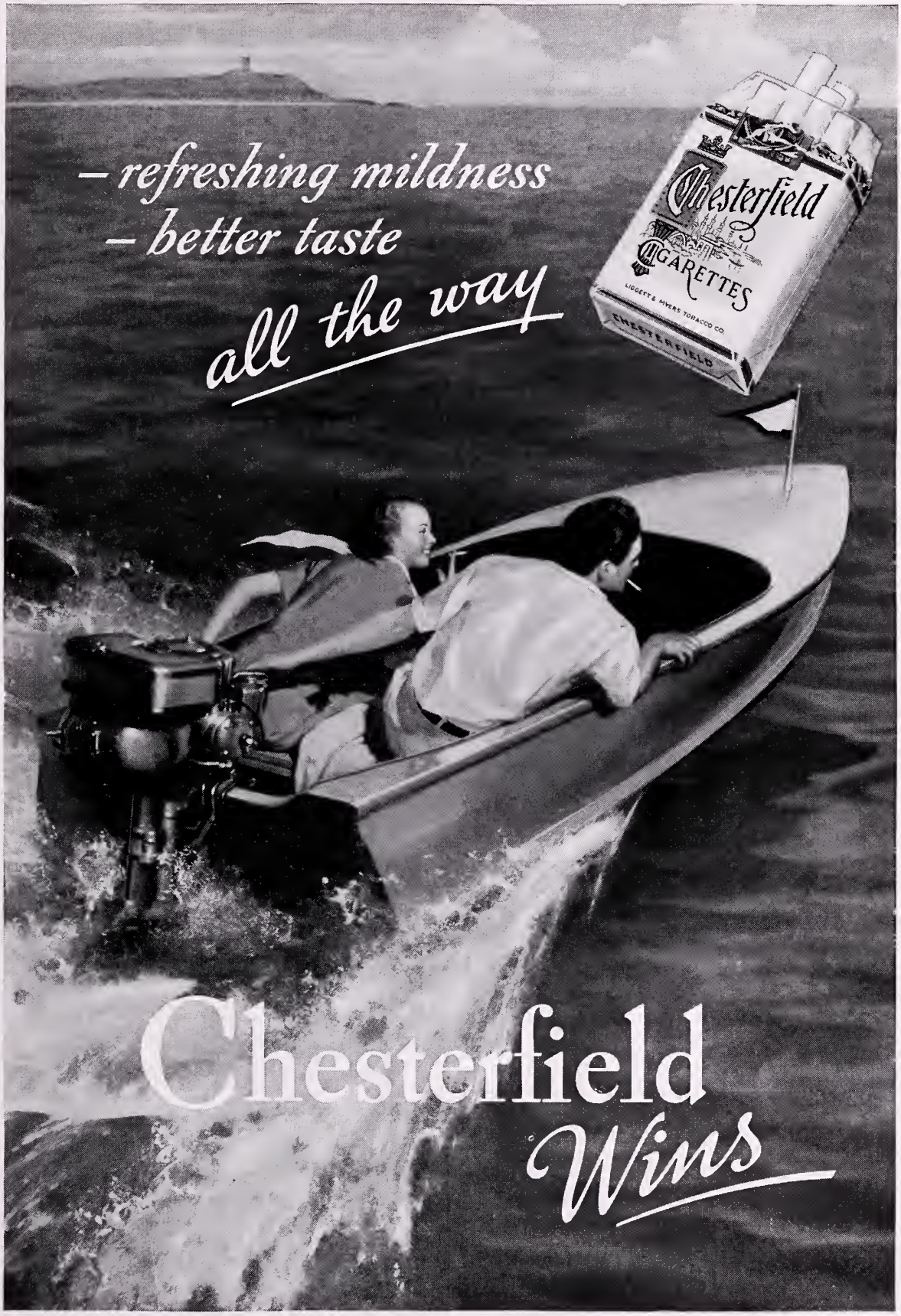
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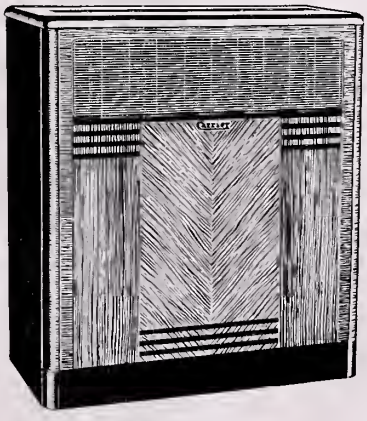
In This Number

Intestinal Tuberculosis, by Dr. George A. Moore

Minutes of the One hundred twenty-sixth Annual Meeting continued

Officers, Committees and Fellows of the Providence Medical Association on Pages XII, XIII, XIV

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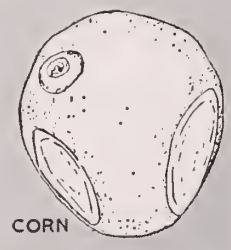
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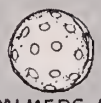
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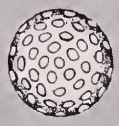

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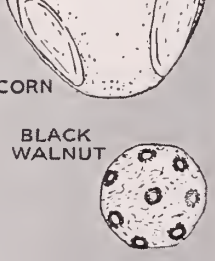

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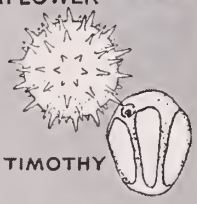

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(1) 1936, Food Research, 1, 1

(2) 1936, J. Biol. Chem., 116, 717

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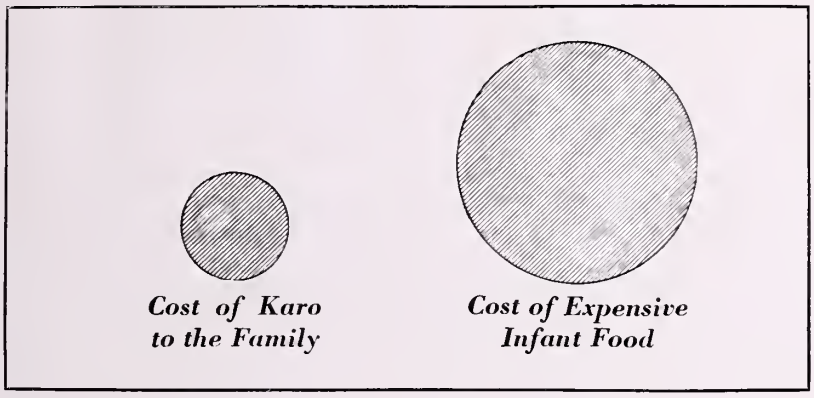
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(HOLT AND McINTOSH: HOLT'S DISEASES OF INFANCY AND CHILDHOOD, 1933)

One of the outstanding features of DEXTRI-MALTOSE is its low fermentability and consequent preference in the management of infantile diarrhea.

In summer diarrhea, "The best food to use is boiled skimmed milk, acid skimmed milk, or dried protein milk. Carbohydrates are added in the form of dextri-maltose."—*G. Wiswell: Infant mortality and its prevention, Nova Scotia M. Bull., 15:504-509, Oct. 1936.*

—•—

Concerning the treatment of diarrhea, "If the weight remains stationary, it is an indication that loss of substance is occurring through the stools, mostly in the form of alkaline salts. To equalize this loss of substance, the diet must be increased, but in such a way as to avoid causing fermentation. This may be done by adding dextri-maltose and preparations of protein to the food, increasing the calories until the infant is taking 160 calories per kilo. of body weight."—*H. L. Ratnoff, Nutritional disturbances, Arch. Pediat., 41:771, Nov. 1924.*

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"A very frequent cause of underfeeding results from the improper treatment of diarrhea . . . One of the greatest advances made in the science of infant feeding was the development of protein milk by Professor Finkelstein and the use of buttermilk or lactic acid mixtures. The great advantage of being able to feed the infant with fermentative diarrhea a food containing 12 calories to the ounce, like protein milk, after only one day on a starvation diet, is apparent. In addition, the further advantage of being able to safely add a carbohydrate like Dextri-Maltose No. 1 or No. 2 to the protein milk within a few days, enables one to gradually bring the infant up to its basal needs in a short time. When protein milk was first used, carbohydrate additions were advised against with the result that many children on it went into a state of collapse. The suggestion of Dr. Alan Brown of Toronto, Canada, that Dextri-Maltose be added to protein milk, was of great value."—*G. J. Feldstein: Underfeeding of infants and children, Arch. Pediat., 50:297-306, May 1933.*

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Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrimaltose No. 1."—*F. R. Taylor: "Summer Complaints," Southern Med. & Surg., pp. 555-559, Aug. 1927.*

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"Again, following the teaching of the originator of protein milk, the carbohydrate added should be the one that is most easily assimilated. Dextri-maltose is the carbohydrate of choice."—*R. A. Strong: The diarrheas of early life, Mississippi Doctor, 14:9-15, Sept. 1936.*

"If the stools are acid, green, and excoriating, a food high in protein and low in fat, and carbohydrate is indicated. Dried powdered protein milk is very ideal here—one to ten dilution. On the other hand, if the evacuations are brown, watery, and stinking with putrefactive odors, a proteolytic diarrhea, it will be of advantage to add a small amount of carbohydrate, a dextrimaltose preparation being very efficacious."—*A. G. Dow: Diarrheas in infants, Nebraska M. J., 20:22-24, Jan. 1935.*

SERIOUSNESS OF DIARRHEA

There is a widespread opinion that, thanks to improved sanitation, infantile diarrhea is no longer of serious aspect. But Holt and McIntosh declare that diarrhea "is still a problem of the foremost importance, producing a number of deaths each year. . . ." Because dehydration is so often an insidious development even in mild cases, prompt and effective treatment is vital. Little states (Canad. Med. A. J. 13: 803, 1923), "There are cases on record where death has taken place within 24 hours of the time of onset of the first symptoms."

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"After the preliminary short period of starvation, protein milk should be used. . . . When the diarrhea has been sufficiently checked, dextrimaltose may be added and gradually increased until from 4 to 6 tablespoons are being used."—*W. L. Denney: Acute nutritional disturbances of infancy, Univ. West. Ontario M. J., 2:192-137, April 1932.*

—•—

In diarrhea, "Carbohydrates, in the form of dextri-maltose, well cooked cereals or rice, usually can be handled without trouble."—*B. B. Jones: A discussion of some of the commoner types of infantile diarrhea, and the principles underlying the diets used in their treatment, Virginia M. Monthly, 55:411-415, Sept. 1928.*

In the treatment of dysentery, "As a useful supplement, Bessau's thick rice water with 1 to 5 per cent dextrimaltose may be used, or soy bean milk, which also may serve as main nourishment in the rare cases of hypersensitiveness to cow's milk."—*O. Willner: Dysentery, in The Practitioner's Library of Medicine & Surgery, D. Appleton-Century Co., Inc., New York, 1935, vol. 7, p. 371.*

—•—

In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—*W. H. McCaslan: Summer diarrheas in infants and young children, J. M. A. Alabama, 1:278-282, Jan. 1932.*

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"When there has been a tendency to looseness of the bowels, a form of sugar which ferments but slightly, such as dextrimaltose, may be employed."—*W. Sheldon: The artificial feeding of infants, Practitioner, 134: 415-428, April 1935.*

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". . . I begin to add carbohydrates slowly, by replacing ¼ ounce Casec every two days with ¼ ounce of Dextri-Maltose, preferably Dextri-Maltose Number one. As a rule, this is tolerated. When one ounce of Dextri-Maltose is used, the Casec, of course, should be discontinued."—*J. W. Reed: The etiology and treatment of diarrhoeas of infancy, Virginia M. Monthly, 53:732-735, Feb. 1927.*

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In treating chronic diarrhea, "You do not need to starve such patients, but you select a diet of dried protein milk with the addition of dextrimaltose given in small three-hourly feeds, or soured milk, or an ordinary half-cream dried milk, or a whey mixture."—*R. Hutchison: Lectures on Diseases of Children, ed. 7, William Wood & Co., Baltimore, 1936, pp. 26, 65, 71-72, 76.*

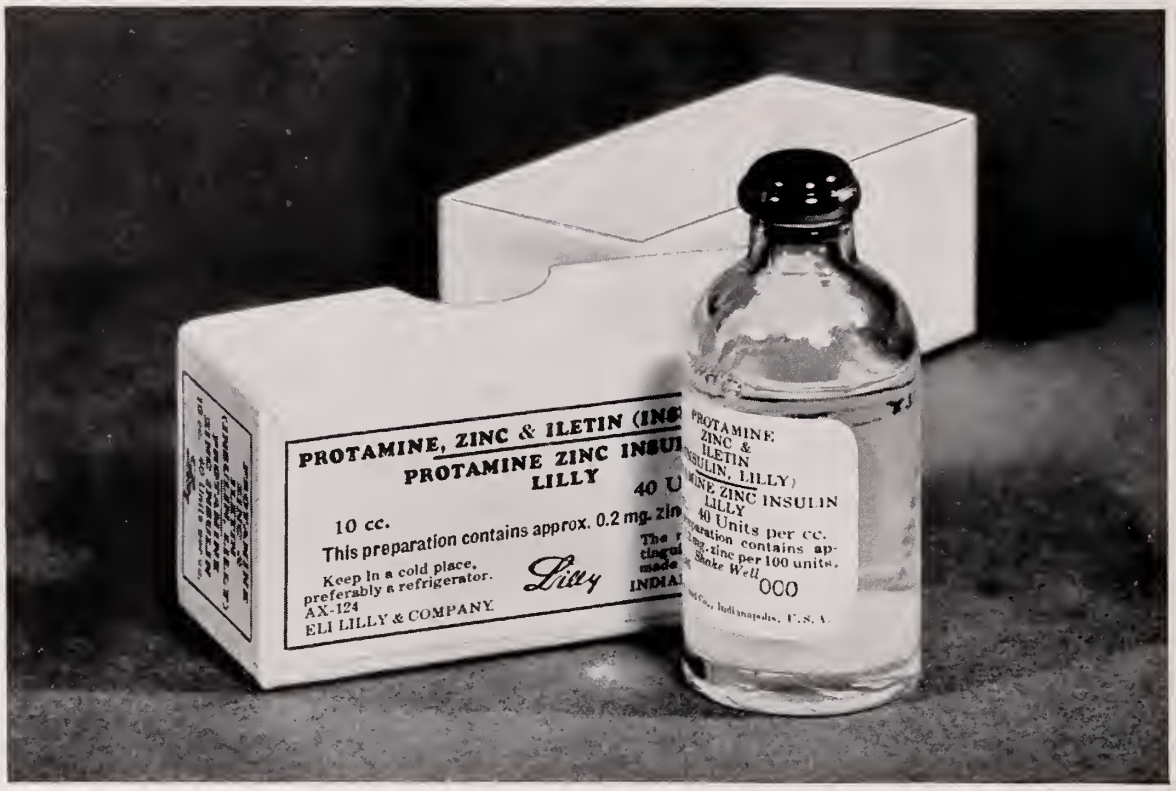
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Just as DEXTRI-MALTOSE is a *carbohydrate* modifier of choice, so is CASEC (calcium caseinate) an accepted *protein* modifier. Casec is of special value for (1) colic and loose green stools in breast-fed infants, (2) fermentative diarrhea in bottle-fed infants, (3) prematures, (4) marasmus, (5) celiac disease.

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Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 8
Whole No. 335
AUGUST, 1937
PER YEAR $2.00
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INTESTINAL TUBERCULOSIS

GEORGE A. MOORE, M.D.
167 NEWBURY STREET, BROCKTON, MASS.

I have chosen a subject, which I am well aware is considered by many, a sanatorium disease, and of rare occurrence in family practice and general surgery. I am convinced, however, that many more cases of intestinal tuberculosis are seen in private practice than are available for statistics, possibly many that are not recognized.

It would also appear from my own experience and from contributions in the literature that there is room for considerable improvement in the treatment of these patients. In recent years there have been advances in the treatment of tuberculous lesions of the intestines comparable with the results of surgical treatment of pulmonary tuberculosis.

Intestinal tuberculosis may be divided into two main groups: 1. Primary, or the rare type of disease characterized by a hyperplasia of the wall of the intestine. In these cases active disease rarely is found in the body. 2. Secondary, or the ulcerative lesions of the intestines, which in practically all cases is a complication of active pulmonary disease. Many writers who have studied the pathology of tuberculosis are skeptical of the existence of primary disease of the intestines except in children. Over 50% of all children and about 90% of all adults have tubercular infections at some time in their lives. An intestinal lesion may well have its origin in arrested disease in the lungs, lymph nodes or elsewhere.

There is still considerable discussion regarding the transmission of the tubercle bacilli to the site of the initial lesion in the intestine. The weight of opinion appears to be in favor of ingestion although there is considerable evidence that in many cases the infection is carried in the blood stream from a ruptured cavity in the lungs or from lymph nodes. The fact that primary intestinal tuberculosis occurs in 34%[1] of the cases in the British Isles where much of the milk is tuberculous, favors the ingestion theory.

Read before the Providence Medical Association, May 3, 1937.

The initial lesion in most cases of intestinal tuberculosis is in the terminal ileum and caecum. It may spread upward from the original focus involving the small intestine or downward in the colon and rectum where the hyperplastic type is more frequent. In the ulcerative type of disease the earliest tubercles are found in the Peyer's patches and solitary follicles, which break down, forming ulcers. These may penetrate the wall of the peritoneum but rarely perforate. The ulcers may progress along the intestines or encircle the mucosa, girdle ulcers. Healing of a girdle ulcer may result in a fibrotic ring with resulting obstruction. The hyperplastic variety is characterized by the formation of granulation tissue in the submucous and subserous layers. This results in a marked thickening of the intestinal wall, more frequently the terminal ileum and caecum. The mucosa is not involved as a rule but is gradually pushed into lumen resulting in constriction.

I have been unable to find any statistics of the incidence of intestinal tuberculosis. Mortality statistics of the Massachusetts State Board of Health[2] group tuberculous peritonitis, mesenteric glands and intestinal tuberculosis together. In these three groups there were 2,501 deaths from 1912 to 1935 inclusive. The highest number 202, occurred in 1916 and the lowest 31 in 1934. In the United States there was an average of 2,200 deaths from these three diseases from 1930 to 1932 inclusive, which dropped to 1,431 in 1935. It is evident that either the widespread campaign against tuberculosis or improved methods of treatment is saving many lives.

Since 1900 at the Massachusetts General Hospital there have been 195 cases diagnosed intestinal tuberculosis, 9 with tuberculosis of the appendix, 52 patients having rectal tuberculosis and 24 with tuberculosis of the anus. At the Lakeville Sanatorium, we have had 39 patients with tubercular lesions of the intestines. This small number is to be explained by the fact that we treat no patients with active pulmonary diseases in which ulcerative intestinal lesions occur as a complication. During the same interval at Lakeville, we have seen 82 patients with mesenteric glands, and 133 cases with tubercular peritonitis.

The most extended study of intestinal lesions complicating pulmonary tuberculosis was carried out by Brown and Sampson.[3] In a routine X-ray examination of the gastro-intestinal tract of 1,801 patients they found 8% had intestinal lesions.

Intestinal tuberculosis is characterized by a very insidious onset and unless the significance of the early symptoms is recognized the most favorable time for treatment is past before a diagnosis is made. Loss of appetite, indigestion, indefinite abdominal pains, constipation and loss of weight are characteristic of the early case. The X-ray examination is frequently inconclusive at this stage.

As the disease progresses, nausea and vomiting occur, abdominal pain becomes more acute especially after eating and is frequently more severe in the right lower quadrant, diarrhea alternating with constipation may occur, the loss of weight is more marked and an unexplained fever is observed. These symptoms are frequently considered an indication for an exploration, when the correct diagnosis may be made or suspected and an unoffending appendix removed.

The most frequent complication in the later stages of intestinal tuberculosis is obstruction. It is of rare occurrence in the ulcerative lesions, since in this type it is caused by healing of a girdle ulcer in the form of a fibrotic band or stricture or adhesion of loops of intestine resulting in angulations. In the hyperplastic type of disease, symptoms of obstruction are common owing to the great increase in thickness of the intestinal wall and gradual narrowing of the lumen. Perforation occurs in a small percentage of cases resulting in a walled off abscess, external fistulae or diffuse peritonitis. Intestinal perforation as a terminal complication occurs in 3% of patients who succumb to pulmonary disease. Ulcerative lesions may involve the colon in rare instances resulting in symptoms very similar to ulcerative colitis except for the presence of tubercle bacilli in the stools. We have seen four cases of this type at Lakeville.

Cancer, regional ileitis, ulcerative colitis and nonspecific granulomas are the most common diseases to be differentiated from intestinal tuberculosis. Cancer occurs in older people as a rule, where tuberculosis is more common in patients under forty. Blood in the stools is more common in cancer, emanciation and anaemia are more pronounced. Regional ileitis is characterized in its early course by symptoms of obstruction; ulceration, perforation, abscess and fistulae are late manifestations. Intractable diarrhea, characteristic stools and prostration help to distinguish ulcerative colitis. The X-ray study is of considerable help. Non-specific granulomas are frequently mistaken for hyperplastic tuberculosis in the gross specimen. The histologic picture is difficult to differentiate. Wilensky and Moschcowitz[4] of Mount Sinai have stated that many cases of hyperplastic tuberculosis have been incorrectly diagnosed by pathologists. At present the field of surgery is limited to the relief of intestinal obstruction, removal of the rare tuberculous appendix and exclusion or in rare cases excision of hyperplastic disease, usually of the terminal ileum or caecum.

Heliotherapy and ultra-violet have brightened the outlook for the patient with intestinal tuberculosis, similar to the results of surgery in pulmonary tuberculosis. Brown and Sampson reported a series of 271 patients treated by ultra-violet with good results in 73%. The interesting fact about their cases was that healing of the intestinal lesion was frequently observed in the presence of progressive and even fatal pulmonary disease. Other writers have reported similar results. Our cases at Lakeville are not given the intensive ultra-violet treatments advocated by Brown and Sampson. We are not convinced as yet that the best results are attained by the deep pigmentation of the skin resulting from the Saranac method. We are giving treatments three times a week and feel that better results are attained by less tanning of the skin. Our cases differ from those that occur in most tubercular sanatoria in that we have none with active pulmonary disease. If the disease is not too advanced complete arrest or marked relief of the symptoms after ultra-violet treatment with the usual sanatorium care results in a high percentage of our cases.

Pneumoperitoneum has been of great benefit in cases of tubercular peritonitis and has been advocated by some recent writers for intestinal tuberculosis. Salkin[5] of Michigan State Sanitorium states that it has been proven of benefit in all moderate cases of intestinal tuberculosis and in 80% of severe cases. He has treated 95 cases with pneumoperitoneum with complete symptomatic relief in 73%. This method may replace ultra-violet and heliotherapy, but as yet we feel that it is still in the experimental stage.

Considerable emphasis has been placed by some writers upon the value of vitamins and low residue diet in tuberculous enteritis. They are of unques-

tioned value in cases with intractable diarrhea and intolerance to the usual diet. Few writers favor this method for all patients with intestinal tuberculosis but prefer a generous well-balanced diet. At Lakeville we are adding cod liver oil and tomato juice to the regular diet in many cases.

A small number of patients with intestinal tuberculosis develop intestinal obstruction and surgery is imperative. The cause of the obstruction can then be determined and at the same time relief obtained by ananastomosis or external drainage. A unilateral or bilateral exclusion of the diseased segment with anastomosis or enterostomy is all that can be done in many advanced cases. Santy[6] reported a series of 20 cases in which primary resection was done in half and an exclusion done in the others. His results were much better in the cases with exclusion. Ultraviolet and heliotherapy were used following the exclusion operation and were found to be of marked benefit after the diseased bowel had been put at rest. Santy advised secondary excision after all benefit from conservative treatment has been obtained and the local disease is not arrested.

Tuberculosis of the appendix deserves mention as in most cases there is a rather prolonged history suggesting pathology in the right lower quadrant. It is also of interest that Archibald[7] and other writers since his first report have noted that removal of the appendix alone in cases of very advanced ileocaecal disease resulted in marked relif from pain.

I am not going to bore you with detailed records of a large number of cases. I would like to cite briefly a few cases that illustrate certain types of disease.

Case Histories

124. Mrs. A. Age 40. December 11, 1917. Patient had pulmonary tuberculosis and had been in a sanatorium, is now six months pregnant. Has increasing constipation for 6 weeks with no movement for past 5 days. Usual symptoms of acute obstruction.

Operation: Several loops of small intestine matted together. Enterostomy, miscarriage 12 hours later. 2½ months afterward, resection of 6 inches ileum and end to end anastomosis. Recovery. 1937 condition excellent.

1381. Mr. S. Age 39. July 20, 1922. A history of general abdominal pain, indigestion and attacks of severe constipation, vomiting and loss of weight for past five years. Complete obstruction for 3 days. Had no pulmonary lesion but had complete transposition of viscera.

Operation: Enterostomtomy. Death. At post mortem, hyperplastic ileocaecal tuberculosis.

2642. Mr. McQ. Age 46. March 5, 1925. General abdominal pain, indigestion without food relief and frequent attacks of severe pain with loss of strength for 5 years.

Operation: Exploratory. Hyperplastic ileocaecal tuberculosis, about 15 annular strictures in ileum and numerous mesenteric glands. Ileostomy. Death in 1927 in tubercular sanatorium.

Lakeville Patients:

1. F. C. female; age 28, admitted January 14, 1937.

Operation at Salem, August 1933, appendectomy followed by fecal fistula. Operation December 1933, repair of fecal fistula. Operation July 1936, M.G.H. colostomy, transverse colon and repair of fecal fistula in recto-sigmoid. Fecal fistula persisted, urinary fistula developed. Guinea pig positive. Now has large firm tumor in right lower quadrant extending into pelvis, involving bladder. Colostomy; fecal and urinary fistulae left lower quadrant.

2. L. R. colored, age 21. Admitted April 1936.

Tuberculosis of 9, 10, 11 dorsal vertebrae. X-ray diagnosis Weymouth Hospital "almost complete obstruction of ileum from old appendix abscess or tubercular peritonitis." Operation, June 1936. Arthrodesis of the spine. Abdominal pain, attacks of vomiting. Operation, October 1936: Resection of caecum and ileum for hyperplastic tuberculosis.

3. E. J. S. female, age 7. Admitted October 1935.

Raw milk at school. Abdomen distended February 1935. Abdominal pain, convulsions. Treated at Children's Hospital, Boston, for mesenteric adenitis. Developed diarrhea and vomiting. Stools positive and gastric lavage positive for tuberculosis. Still has abdominal pain and distention, vomiting and diarrhea. Improving under ultra-violet, tomato juice and cod liver oil.

Summary

The initial lesion of intestinal tuberculosis whether ulcerative or hyperplastic in most cases is in the terminal ileum and acecum. Eight per cent of patients with pulmonary disease have terminal perforations. The onset of intestinal tuberculosis is insidious, the early symptoms are gastric disturbance, abdominal pain, constipation and diarrhea. Pneumoperitoneum has given favorable results but has not been extensively used. Vitamins may be of benefit. Heliotherapy, ultra-violet and conservative surgery appear to give better results than radical excisions except in selected cases.

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7. Archibald: The Surgical Treatment of Ulcerative Intestinal Tuberculosis as occurring chiefly in the Course of Pulmonary Tuberculosis. Canadian M. Ass. J. 10:1920:804.

Discussion

Dr. Edwin D. Gardner, New Bedford, Mass.: I think we all agree that Dr. Moore has read a very comprehensive paper. I cannot argue with him because in the first place there is no argument and in the second place, having worked only in a general hospital, I have seen comparatively few cases of intestinal tuberculosis. Undoubtedly, Lakeville Sanatorium has done very good work in intestinal tuberculosis and almost surely has reduced the mortality in abdominal tuberculosis in Massachusetts from 202 deaths in 1916 to 33 deaths in 1935. I think Dr. Moore should be congratulated.

I should like to speculate somewhat on another phase of this subject which may or may not pertain to intestinal tuberculosis.

About 1919 I began to see many cases with the following findings: A child or a young adult, sometimes and sometimes not with a history of a common cold about two weeks previously, comes into the hospital with the story that 5-6 hours to 24-48 hours before entrance, he began to have constant abdominal pain, either in the right lower quadrant or the epigastrium or about the umbilicus. This has persisted and is usually accompanied by nausea and vomiting. Occasionally there is a history of diarrhœa, but usually not. Ordinarily this is the whole history. On examination there is tenderness over MacBurney's point, very little if any spasm. Otherwise the physical examination is negative. Sometimes the white count is elevated and sometimes not. The temperature is usually slightly elevated, rarely up to 101 or 102. Pulse and respirations are not remarkable. The urine is negative. It has been my practice to operate on those cases if the temperature is not too high for the other signs, if the white count is elevated, and particularly if there is definite spasm. Sometimes I find definite acute appendicitis, which is the reason for operating. Frequently, however, I find many enlarged and edematous glands in the mesentery of the terminal ileum, some congestion of the terminal ileum, and possibly the cæcum and appendix. Occasionally there is some thickening of the terminal ileum, but usually not. Usually there is considerable free, straw-colored, clear, odorless fluid and nothing more. Of course, the appendix is removed and the convalescence is uninterrupted. The follow-up has shown nothing. Of course, maybe if the follow-up could be continued long enough something would be uncovered. I do not know.

What are these cases? What shall be done about them? Surely such radical surgery as resection is out of the question. Are they the forerunners of so-called regional ileitis, or are they early cases of tuberculous enteritis? At one time I wondered if the influenza epidemic of 1918-1919 was the cause of these cases. Should all of these cases receive the general care that we give tubercular cases?

Another thing I should like to ask Dr. Moore is, how he differentiates betwen so-called regional ileitis and tuberculosis of the ileum? I use the words so-called because as I understand it, the so-called "regional ileitis" can occur in any part of the ileum or jejunem or even in the colon.

So far as I know, the symptoms and outcome of both of these conditions are identical. Some of both apparently get well spontaneously, and some go on to intestinal obstruction and fistular formation. Those cases that come to operation or autopsy, show marked fibrosis and both even have marked giant cell formation. Of course, if typical tubercles and tubercle bacilli are found the diagnosis is easy, but it is not always easy to find tubercle bacilli, even if they are present.

I frequently wonder if both of these diseases have not a tubercular foundation.

I wish to thank Dr. Moore for his very excellent paper and the members of this society for giving me the privilege of discussing it.

THE TREATMENT OF CANCER OF THE CERVIX UTERI AT THE RHODE ISLAND HOSPITAL. 293 CASES WITH 5 YEAR FOLLOW-UP

Herman C. Pitts, M.D., F.A.C.S., and George W. Waterman, M.D., F.A.C.S.

After discussing briefly the methods of treating cancer of the cervix in different clinics here and abroad and the rationale of the various methods, the authors describe their method used at the Rhode Island Hospital, and review their results in a series of 120 cases treated from 1921 through 1925, where the *older* method of surface and intracaviteal radiation with 25 mgm. and 50 mgm. silver and brass filtered capsules and occasional use of short steel filtered 5 mgm. needles interstitially, was in use, as against their results in a series of 173 cases treated from 1926 through 1930, where the use of long needles of low intensity and platinum filtration (.5 mm.) interstitially in cervix and paramet-

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Author's Abstract of a paper published in Surgery, Gynecology & Obstetrics, January, 1937, p. 30.

rium combined with the use of a 20 mgm. capsule in the cavity was used. Their results as summarized are given as follows:

Survived 5 years	79 of 293 cases 1921-1930	26.9%
Survived 5 years	24 of 120 cases 1921-1925 (by older method)	20.0%
Survived 5 years	55 of 173 cases 1926-1930 (by newer method)	31.7%

The authors have broken down the figures of the last 5 years to show the effect of an increase in the time interval of treatment as follows:

1926-1928, when interval was 72-96 hours and total dosage 3000-5000 mgm. hours, the survival rate was 27:96 or 28.1%.

1929-30 when the interval was raised to 144-168 hours or 6000-10000 mgm. hours, the survival rate was 28:77 or 36.3%.

The authors have likewise given tables in which the extent of involvement when first seen is shown, cases coming early with small lesions being put in the Stage I group; those with more advanced lesions but still limited to the cervix being in Stage II; and the more advanced lesions with involvement beyond the cervix being in Stage III. Finally the complete involvement of the pelvis with large masses filling both sides (frozen pelvis) is put in Stage IV.

They find a marked and to them significant improvement in the Stage III cases, i. e. those with definite parametrial involvement or extension beyond the cervix, as follows:

Period 1921-1925 — Stage III — older method 6:43 or 14% survived the five year period and 3 of these died in the 6th year so that only 3:43 or 6.9% survived 6 years after treatment.

Period 1925-1930 — Stage III — new method 18:62 or 29% survived for five years and 17:62 or 27.4% alive 6 years.

In order to show that their method of placing long platinum needles into the parametrium is not dangerous, i. e. does not carry a high mortality from peritonitis and infection and a high morbidity with fistula formation, the authors have given their figures as to immediate mortality and fistula formation and find no increase. In fact their incidence of fistulas has been less under the new method.

The authors conclude that in their hands the use of long platinum filtered needles for a single treatment of long time interval with wide distribution of the small foci of radiation has brought about a marked improvement in their results as judged by the 5 year survival criteria.

DERMATORRHEXIS

WITH DERMATOCHALASIS AND ARTHROCHALASIS (THE SO-CALLED EHLERS-DANLOS SYNDROME)

F. Ronchese, M.D.
Providence, R. I.

Parts of the syndroms described by Ronchese under this new title have been reported under various denominations, viz., dermatolysis, cutis laxa, cutis hyperelastica, loose skin, india rubber skin, etc., none of them satisfactory. The syndrome consists of three symptoms: (1) pronounced fragility of the skin and its blood vessels, with breaking, splitting and the formation of hematomas and pseudotumors subsequent to the slightest trauma (dermatorrhexis-fragilitas cutis), (2) a more or less pronounced hyperlaxity and hyperelasticity of the skin (dermatochalasis-laxitas cutis) and (3) more or less pronounced hyperlaxity or hyperflexibility of the joints (arthrochalasis-laxitas articularis). Obviously the main feature of the syndrome is the fragility of the skin with the consequence of disfiguring scars. This is the reason for naming the whole syndrome from the main symptom. Particularly in this country little attention has been paid to this syndrome by dermatologists, pediatricians and orthopedic surgeons.

Three cases from the Department of Dermatology of the Rhode Island Hospital are described. The syndrome does not seem to be so extremely rare as many authors maintain. After the experience of the first two cases, the third was immediately diagnosed by the admitting physicians. Twenty-seven cases have been reported in the literature; only one in the American literature. The syndrome is well defined and constitutes a clinical entity to be included in the group of congenital dystrophic anomalies. The etiology and pathology are obscure.

Designation of syndromes by proper names is discouraged. However, F. P. Weber (Br. J. Derm. 48: 609, Dec. 1936), while highly praising Ronchese's paper, prefers the heading "Ehlers-Danlos Syndrome."

From the Department of Dermatology, the Rhode Island Hospital.

Résumé of a paper printed in the *American Journal of Diseases of Children*, 51, 1403, June, 1936.

THE RHODE ISLAND MEDICAL JOURNAL



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106 Francis Street, Providence, R. I.

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IT CAN HAPPEN HERE

One of the tragic sights which the physician sees all too frequently is an individual who has unknowingly been deceived, misdiagnosed, and ill-treated by an ignorant individual posing as a trained man under the title of chiropractor. And it is particularly pathetic when the legislators of his State not only sanction this man who may have been trained by a correspondence course, but even appear ready and willing to champion him. This backing has been obtained in Rhode Island by the great American trick of maintaining a good lobby and a lot of baloney. By the former the chiropractors have succeeded in preventing the passage of a Basic Science Law, a bill which every medical man admits is minimal in its requirements and by the latter they attempt to obtain a good name before the public. So far they have been successful in at least some respects. But, as Al Smith has said—"Let's look at the record."

A chiropractor recently had the audacity to advertise in a Providence newspaper to the effect that he was "just from New York". It is presumed that this important point would help to fill his office. But he does not tell the whole truth. For he was forced to leave that metropolis by the passage of a law denying those of his ilk the right to practice the healing art!

"And look at this." A case which involved the testimony of a chiropractor recently came before the Supreme Court of Ohio. The learned justices of this sovereign state proclaimed once and for all that chiropractors do not practice a healing art, and ruled out that testimony.

So there is the handwriting on the wall. What can be done about it in Rhode Island? What can you as a physician do to eliminate these parasites from our midst? The answer is straightforward and simple. First, join the Rhode Island Medical Society if you are not already a member. There is weight in numbers; an opinion expressed by the whole medical body of this State must mean something! Next is to insist on an expression of that opinion. And that is to be done, not by just a motion passed in meeting, not just by a speech at a legislative hearing, but by a good, active, well-paid lobby. We as a Society do not need to indulge in baloney for we have the truth. But we should employ a lobby as good or better than the quacks, and make that truth known and understood by every legislator on the hill.

So with the results of New York and Ohio already recorded, let us unite in adding the name of Rhode Island to the roll. It can happen here!

STREET LIGHTING

During the year 1933, in the normal hours of darkness, 324,610 automobile accidents resulted in 16,230 deaths and 381,540 personal injuries in the United States.

The statistics show that

1. The rate of death per accident is much greater at night.
2. Most pedestrian fatalities occur at night.
3. Night fatal accidents are doubled in winter (dark) versus summer (light) months.
4. Main highway and rural fatalities are increasing.
5. Night-time accidents and fatalities are increasing at a faster rate than day fatalities.

Why? The provisions for street lighting have

not kept pace with other expenditures. There is really only one vitally important difference between day-time and night driving. The car is unchanged; the roadway has the same surface and is just as wide and winding; the miles are of the same length; and the towns are just as far apart. There is usually less traffic at night and this has some bearing; but the chief difference is our ability to see for long distances by day as compared with our limited range of vision by night.

Then there is that reaper of death, glare from improperly adjusted headlights. Who hasn't encountered glaring headlights at night? We have all experienced the sensation of taking one last look at the road ahead, setting the steering wheel where the road should be, and praying that we don't get hit, hit someone else, or end up in the ditch. But why are improperly adjusted headlights glaring at night? They certainly aren't in the day-time. Simply because of the extreme contrast between these bright sources of light and the surroundings adequate highway illumination will destroy this contrast. There is no glare of headlights in the whiteway districts of our larger centers.

Ordinarily, in driving, the pupil of the eye is wide open to allow as much light as possible to enter the eye. As the glaring headlights approach, there is an immediate contraction of the pupil to a very small opening to keep out the glare. Then the glare passes. However, the pupil of the eye opens more slowly than it closes. For every second during which the pupil is contracting, it requires approximately one minute of expansion for the vision to be adjusted to give the same seeing ability on the road after the glaring headlights have passed. These are the reasons for our temporary loss of visibility. Is it any wonder that many pedestrians are seen too late? Proper illumination of the roadways would permit of driving with depressed headlight beams and less powerful headlights, eliminating this extreme contrast and glare.

If all night traffic accidents could be eliminated, the economic saving each year would pay the salries of all the teachers, supervisors, and principals of all the elementary and secondary schools in this country. In addition, the lives of 15,000 people would be saved each year—a number equal to more than one-fourth of all Americans killed during the entire World War.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the One Hundred and Twenty-sixth Annual Sessions

Meeting of the House of Delegates

(Continued from Page 120)

Report of the Committee on Public Health Clinics

During the year, your Committee has continued its efforts to obviate conflicts between the private practice of medicine and other agencies concerned with health. The Chairman has continued his contact with the nursing agencies and has attended their conference. It is felt that the interchange of viewpoints has been decidedly helpful and that definite progress is being made.

Early in the year the Committee met and drew up an outline to be followed in the event any group of physicians in a given locality desired to emulate the policies and procedures of the East Providence Physicians' Association or the Caduceus Club. A copy of the outline is appended and made a part of this report.

The Chairman was invited to discuss the outline before the Woonsocket Medical Society and the plan is now under consideration there. An invitation to present a similar paper in Westerly came at an unfortunate time and could not be taken advantage of. It is hoped that a similar opportunity will again present itself.

A special meeting of the Committee was held on February 11, 1937, to consider complaints received from roentgenologists regarding the X-ray department of the Providence Tuberculosis League. It was brought out at the meeting that the League is a body supported to a large extent by grants from the Community Chest and therefore is a charitable agency; but that it has recently extended or attempted to extend its field of diagnosis to groups of food handlers and others. The extension of this service was discussed at length by all present and it was admitted by Dr. John Pinckney, representing the League, that the sort of X-ray examination that was given by his department was not equal to the minimum standard set by private roentgenologists. Dr. I. Gerber stated that he did not consider the examination by the League method to be adequate. Dr. Pinckney admitted that it was not, and further stated that he considered that the health of Provi-

dence citizens as regarded tuberculosis was his responsibility. The Chairman pointed out that this is an unwarranted assumption of responsibility and commented that such responsibility belongs to the entire medical profession and not to any lay or welfare organization.

The Committee is on record as believing that the health of the community is the responsibility of its physicians. Today, with advancing knowledge through lectures, newspapers and radio, the League could better reserve by using its position to direct public attention to the need for complete and regular checkups with the family physician and to serve only the indigent properly referred to it.

The physician who refers and the clinic which accepts a patient who should be in the office of a private physician definitely harms the rest of the profession and is aiding and abetting the clinical abuse which your Committee is trying hard to correct. When a specialist in internal medicine sees a patient in his private office and charges a fee of $5.00 or at times $10.00 in the same family, and then refers that family for X-rays to the Providence Tuberculosis League instead of to a reputable fellow practitioner specializing in roentgenology — then no wonder we find the "Clinic Problem" so vexing. If we are to be faced with contract practice and extension of welfare service to the detriment of private practice, some attempt should be made at present to correct this evil before it is well established. As a result of your Committee's activity there has been a definite crystallization of opinion among the roentgenologists and proper steps are being taken to meet and to solve similar problems.

Again your Committee urges the formation of medical groups either within or without the regular medical associations for the discussion and solution by group action of the many medico- and socio-economic problems that beset us today. The Chairman was also invited to discuss such group action before the Kent County Medical Society. The members are at present examining the feasibility of the plan for their needs.

In closing, the Committee again offers its assistance to any individual or group within the profession for the elimination of conflicts with private practice.

Respectfully submitted,

CHARLES L. FARRELL, M.D., *Chairman.*

Suggested Outline for Formation of Medico-Economic Group

All local physicians to meet and agree that their interests are best served by agreeing to the following principles:

1. The health of the community is the responsibility of the physicians and this responsibility is best met by a uniform attitude among the physicians, both toward each other and toward the health and welfare agents in their locality.

2. The attitude of every physician to the health problem should be uniform and be formulated as a result of a free and frank discussion of each individual's ideas as to what constitutes the best plan for united thought and action.

3. Assume the leadership in instituting public health instruction and public cooperation in disease prevention.

4. Deputize one or two members to act as a committee to investigate and correct situations inimical to the prerogatives and privileges of the physicians in private practice.

5. Study the needs of the community and officially authorize one or more members to represent the physicians in contacting the proper parties and to assist in correcting the defects or abuses under consideration.

6. Notify all health and welfare agencies of the district that in initiating any program of health or welfare activity involving the free services of physicians that the medical profession of the district must first be interviewed and their attitude considered before proceeding with the project.

7. Arrange with the health unit of the State Department of Health to cooperate in its work and to enlist its support and influence to promote a better community understanding of the physician's place in the scheme of things in his locality.

8. Standardize the forms of medical practice as regards preventive medicine—prenatal care, infant care, care of the pre-school child—as well as refer work—tonsillectomy, X-ray, surgery, and tuberculosis cases.

9. Agree on uniform attitude toward fraternal, society and contract practice, industrial accident care and food handlers examinations.

10. Agree among each other to accept no clinical work or to give free services to any group for any purpose whatever, no matter how worthy, until the plan has been put before all the physicians, meeting as a group, and analyzed as to its need and desirability.

11. Emphasize the attitude that the profession stands ready at all times to give its free and active support in any situation for human betterment when it has a voice in the direction and extent of the work and is certain that such work does not encroach on the rights and prerogatives of the family physician.

Technique for Application of the Above Suggestions

1. Hold a meeting and officially form a medical group with nominal dues for stationery, postage, telephone calls, etc. Draw up by-laws; may use example of Caduceus Club.

2. Agree to meet and discuss all medico-economic and medico-social problems and agree to be bound by the will of the majority.

3. Work for a school physician and formulate a plan of action for the said school physician acceptable to all, define and limit his duties and have him refer all defects to the family physician for correction and not to a clinic.

4. Cooperate with District Nursing Association in defining and limiting the duties and activities of nurses, specify that no nurse shall visit a patient more than once without contacting the doctor on the case and then to limit her activities to his specific orders. In the event that a district nurse discovers a case not under the care of a physician, that she may revisit once in order to insist on medical care but not to continue such visits without authorization from some physician. In no case is a nurse to give an enema, eye wash, or apply any medications without written orders of a physician. In no case is a nurse to refer a patient to a specific doctor and she is never to refer to a clinic. Nurses should not arrange for clinic care, even on request of the patient or an organization, unless requested to do so by a physician.

5. Interview school officials and work for regulations requiring pre-school examination of all children entering school for the first time; this work to be done by the family physician and not as a clinic activity. Give informal talks before parent-teacher associations on health subjects and child guidance. Enlist their cooperation but do not fall in with schemes proposed by groups using the free services of physicians in school clinics attended by children who should be visiting their family physician.

6. Self explanatory.

7. In an effort to prevent State Medicine and the taking over by the State of smallpox vaccination and diphtheria immunization it is essential that local physicians make some provision for doing this work, either in their offices or as a public health measure. The technique can be varied for the needs of individual localities. The Pawtucket plan could be used if desired.

8. Agree on routine procedures in certain cases; routine urine and blood pressures in prenatal monthly, monthly examinations of infants from birth to six months at which time formulae are modified, at the sixth month routine vaccination and immunization against diphtheria, tuberculin testing, thorough physical examinations of pre-school children and follow-up to check defect. Such procedures will eliminate clinics for the above and prevent State encroachment on private practice.

9. Agree not to enter into contract practice detrimental to the public and other physicians, or to agree to render service under conditions which make it impossible to render adequate service to the patient or which interfere with reasonable competition among fellow physicians. Very soon persons representing insurance companies will attempt to sign up physicians to care for insured persons at a rate less than usual and to direct all such insured persons to one particular physician. Such schemes are detrimental and are bound to fail if all physicians turn them down. Agree not to issue certificates of health to food handlers without a physical examination including smear and Wassermann. Forms may be mimeographed and distributed to all physicians so that issuance may be uniform.

10. If approached to examine a group of Boy Scouts or to examine a group of pre-school children, defer action until the matter has been thrashed out pro and con before the medical group and a plan of action agreed upon.

In the event that 100 per cent cooperation between physicians cannot be obtained, it is suggested that you go ahead with the plan as outlined as best you can; then those physicians not cooperating will be free lances and while they as such are free to engage in practices not approved by the majority, they will soon tire of thus disposing of their services. The fact is that physicians outside of a medical group seldom are a big factor in the medico-economic life for many years and are usually not sought after by philanthropic agencies. Newcomers in the medical field should be received warmly and every effort made to mould their opinion and activities for the best interest of all physicians in the locality.

A united medical profession cannot be exploited and such a union keeps otherwise recalcitrant members in line.

Report of the Committee on Education

1. As in the past two years, popular health talks were given under the auspices of the R. I. Medical Society. The meetings were held on Sunday afternoons during the months of November and March at the Medical Society.

2. There were nine lectures given and fourteen speakers addressed the lay public. The following subjects were discussed:

"Common Diseases of the Skin."
"The Care of the Infant and Diseases of Childhood."
"Why People Misbehave."
"Facts and Fancies About Arthritis."
"Diseases of the Eye, Ear, Nose, and Throat."
"Cancer—Facts and Fancies."
"Headache—Medical and Surgical Aspects."
"How to Grow Old Gracefully."
"Why Poison Yourself?—The Nostrum Evil."
"Modern Trends in Obstetrics."

3. The meetings were well attended, extra chairs were necessary and the balcony required to seat the enthusiastic audience. The informal question period was well received.

4. Publicity was extensively employed to stimulate interest in the meetings. The *Providence Journal* and *Evening Bulletin* generously published photographs of the speakers, announced the meetings and printed a splendid abstract of the individual lectures. A large amount of our paid advertising was made possible through the generosity and courtesy of Blanding & Blanding, Inc.

5. The speakers made every attempt to acquaint the public with advancements in medical science, to encourage an optimistic attitude toward disease and to dispell fear; they stressed the importance of early diagnosis, the importance of the family physician, and gave considerable thought to preventive medicine. The subjects were presented in a manner to be easily understood by the average layman.

As the Sunday meetings are attended chiefly by the lay public of Providence, it seems advisable for the county societies to sponsor a similar educational program and to function independently of the State Society. It is doubtful whether the Providence meetings can ever adequately cover the entire State. The committee suggests that the County Societies seriously consider such a plan.

Respectfully submitted,

Russell S. Bray, M.D., *Chairman.*

Books Given by Dr. John E. Donley for the Davenport Collection

A Physician's Anthology of English and American Poetry. Selected and arranged by Casey A. Wood and Fielding H. Garrison.

Thomas Linacre. By William Osler.

Counsels and Ideals from the Writings of William Osler.

Arabian Medicine and its Influence on the Middle Ages. 2 volumes. By Donald Campbell.

The Life of Edward Jenner. By F. Dawtrey Drewitt.

The Life and Convictions of William Sidney Thayer. By Edith G. Reid.

Surgical Memoirs and Other Essays. By James G. Mumford.

The Century of Columbus. By James J. Walsh.

Old Masterpieces in Surgery. By Alfred Brown.

The History of St. Bartholomew's Hospital. 2 volumes. By Norman Moore.

Report of the Trustees of the Medical Library Building

Only one meeting of the Trustees of the Building was held before the death of our Chairman, Dr. James W. Leech. At that meeting it was decided to purchase new shades for the Hall and also for the Reading Room. There have been no further meetings.

Respectfully submitted,

Edward S. Brackett, M.D.

Report of the Publication Committee

Dr. F. N. Brown resigned as Editor on January 1st, 1937. Dr. A. H. Miller was appointed Managing Editor on that date. Dr. C. W. Skelton was continued as Business Manager. As Associate Editors the following were appointed: Drs. William P. Buffum, Alex. M. Burgess, Francis H. Chafee, Henri E. Gauthier, John C. Ham, Thad. A. Krolicki, Edward V. Murphy, Malford W. Thewlis, George L. Young. More pages of reading matter have been published and at less cost.

Respectfully submitted,

Lucius C. Kingman, *Chairman.*

Report of the Committee on Emergency Medical Relief

Dr. Charles F. Gormly, Chairman of the Committee on Emergency Medical Relief, submits the following report of the Medical Director of the State Unemployment Relief Commission:

Dear Mr. Gormly:

The following is a report of my activities as Medical Director of the State Unemployment Relief Commission. To my office in the State Office Building come requisitions for hospitalization, confinement care, various surgical and medical appliances, special prescriptions, glasses, dental treatment, X-rays, and doctor's bills for adjustment, where the charges are not strictly in accord with the Medical Plan. These are sent in by the Case Work Supervisors in the various districts throughout the State and authorizations are sent to them. All of these requisitions and copies of the authorizations, with the aid of my secretary, Miss Sevigny, are filed for ready reference, as well as copies of the examinations of men and women to determine their eligibility to work on State Unemployment Relief.

Since December, 1935, authorizations for hospitalization at $2.00 per day were sent to the Rhode Island, St. Joseph's, Miriam, Charles V. Chapin, Notre Dame, Memorial, Woonsocket, and Westerly Hospitals to the number of 762. Authorizations for confinement care at $2.00 per day were sent to the Providence Lying-In Hospital numbering 167 and to various other hospitals, including St. Joseph's, Homeopathic, Memorial, Miriam, and Woonsocket Hospitals, to the number of 58.

Authorizations for confinement care by doctors in homes were sent to the number of 109, for an average fee of $25.00. Authorization for surgical appliances as abdominal belts, trusses, special corsets, back braces, special shoes, arch supports, caliper braces, splints, etc., to a total cost of $2,421.22. Authorizations for special prescriptions were provided at a total cost of $72.40. Authorizations for eye glasses were furnished for 1,040 clients to a total cost of $4,504.55 or an average cost of $4.33 per pair. Authorizations for dental treatment were provided to a total cost of $986.25. Authorizations for X-rays were furnished to a total amount of $792.70.

Below are tabulated figures for the months from September 1936 through April 1937:

State of Rhode Island
Doctors — Prescriptions — Appliances

	Medical	Hospitals
September	$ 4,651.05	$ 2,980.75
October	3,979.37	2,725.68
November	4,045.72	3,073.68
December	4,725.19	3,090.51
January	5,061.59	2,566.18
February	7,723.68	3,075.05
March	8,433.55	3,095.65
April	6,489.22	3,925.60
	$45,109.37	$24,533.10

City of Providence

	Doctors	Hospitals
September	$ 1,657.67	$ 2,060.36
October	1,483.42	2,175.90
November	1,697.89	2,322.16
December	2,303.84	1,850.68
January	3,075.51	2,282.00
February	3,967.62	2,415.00
March	2,952.14	3,043.90
April	2,661.99	2,226.84
	$19,800.08	$18,376.84

	Prescriptions	Appliances
September	$ 396.93	$166.55
October	409.35	124.86
November	470.92	58.17
December	611.91	47.26
January	927.07	69.97
February	1,130.40	92.85
March	703.22	58.85
April	678.59	159.75
	$5,328.39	$778.26

During the months of December, 1936, and January, 1937, through April, 425 men and women were examined by me to determine their eligibility for employment on S.U.R.; at my office in the State Office Building, as well as in the Pawtucket Department of Health, Central Falls Police Station, Rockwell House in Bristol, and my own office. Of this number, 199 were declared ineligible for employment.

Yours very truly,

HENRY J. HOYE, M.D.,
Medical Director.

Providence, May 20, 1937.

Report of the Publicity Committee

At the Annual Meeting of the State Society in June, 1936, the President, Dr. Roland Hammond, appointed the following Publicity Committee for the State Society: Dr. J. W. Leech, Chairman; Drs. R. S. Bray, P. P. Chase, C. Bradley, G. G. Dupre, Stanley Sprague, A. M. Tartaglino, G. L. Young, and J. W. Helfrich. The original purpose of the committee was to abstract scientific papers for the lay press, to serve as a mouthpiece for the medical profession to the press, and to institute propaganda for the enactment of beneficial, and defeat of harmful legislation. In September, 1936, the committee suffered an inestimable loss in the death of the Chairman, Dr. J. W. Leech. During the year various changes were made in the personnel of the committee and after February 1, 1937, it consisted of Drs. C. Bradley, Chairman; P. P. Chase, Providence; G. G. Dupre, Woonsocket; Stanley Sprague, Pawtucket; A. M. Tartaglino, Newport; and G. L. Young, East Greenwich.

During the year the committee submitted to some of the newspapers of the State more complete reports of medical meetings than had previously been available, including abstracts of the scientific papers presented. Considerable data was also obtained from the American Medical Association and from other state medical associations as to their methods of handling publicity. Although several newspapers had been notified that such a committee existed and would be glad to assist in the interpretation of scientific papers for the lay press, no demand was made for this service. No propaganda in relation to medical legislation was handled during the year.

In the spring of 1937 preliminary notices of the State Meeting were broadcast to approximately twenty-five news organs published in the State of Rhode Island. A definite attempt has been made to secure their cooperation and to assure adequate coverage of the 1937 Annual Meeting.

The following points are suggested for the further consideration of the work of this committee:

(1) That the name "Public Relations Committee" would be more in keeping with the terminology adopted by other state societies and would possibly be more in keeping also with the traditions and standing of the State Medical Society than the present name of the committee.

(2) That the committee assist whenever possible in wider and more accurate publicity regarding all meetings of a medical nature including those of district and special societies.

(3) That the committee release periodically during the coming year to all recognized news organs in the State such items of medical interest as would be of educational value to the public and bring desired publicity to the State Society.

(4) The State Committees on Education and Legislation are already supplying very desirable publicity for the State Society and might be assisted in this by the Publicity Committee.

Respectfully submitted,

CHARLES BRADLEY, M.D., *Chairman.*

Rhode Island Hospital

SCHEDULE FOR AUGUST, 1937

Mondays

10:00 A. M. August 2, 16, 30
I Surg. Grand Rounds
August 9, 23
II Surg. Grand Rounds

4:30 P. M. Thoracic Clinic

Tuesdays

9:00 A. M. Gastro-Intestinal Clinic

10:00 A. M. August 3, 17, 31
II Surg. Grand Rounds
August 10, 24
I Surg. Grand Rounds

Wednesdays

10:00 A. M. Tumor Clinic

12:00 noon. Skin Clinic

Thursdays

9:00 A. M. Orth. Grand Rounds

11:00 A. M. Thoracic Clinic

Fridays

11:00 A. M. Fracture Grand Rounds

11:00 A. M. August 6, 20
Pediatric Grand Rounds

11:30 A. M. Heart Conference

7:30 P. M. August 6
G. U. Staff Meeting

8:30 P. M. August 6
Surgical Staff Meeting

Saturdays

9:00 A. M. Neuro. Grand Rounds

10:00 A. M. Medical Conference

Dr. Alex M. Burgess is combining business with pleasure on a trip to England, Scotland, Norway, Sweden, Denmark and Germany. On July 29, at Manchester, he gave a lecture and demonstration of his method of oxygen therapy. He has been asked to give a similar lecture and demonstration

at Edinburgh. Dr. Burgess is accompanied by his wife and his son, recently graduated from Harvard Medical School. His son will remain for six months study of pathology at Innsbruck. Dr. and Mrs. Burgess will arrive home about September 3.

Dr. and Mrs. Herman A. Lawson have a third son, born at the Lying-In Hospital on July 4th.

Dr. Henry Hoye, a member of the Consulting Staff of the Hospital, has been appointed Superintendent of the State Home and School.

Dr. Ralph D. Richardson completed his two years' internship on July 1st and is now acting as Assistant Superintendent for the Summer months. Dr. Richardson is a graduate of Brown University and Harvard Medical School.

On July 1st, Dr. Katharine Knox Cutts terminated her internship in Pathology.

Dr. Edward R. Squier began his dental internship July 1st. Dr. Squier's home is in Providence. He is a graduate of Brown University and Tufts Dental School.

Dr. Charles S. Bryan, of Providence, began his internship June 15th. Dr. Bryan is a graduate of Harvard College and Harvard Medical School.

Dr. Charles Purcell Roberts, of Atlanta, Georgia, and a graduate of Emory College and University, started his residency for one year in Cardiology July 1st. Previous to coming here, Dr. Roberts served as intern at the Peter Bent Brigham Hospital, from October, 1935, to July 1st, 1937.

Dr. Edward B. Medoff has opened an office for the general practice of medicine at Woonsocket, R. I. Dr. Medoff was intern at the Rhode Island Hospital from January, 1934, to January, 1936.

Dr. James Edward Feldmayer started his Pathological Internship July 1st.

Memorial Hospital

A Round Table Conference on various diabetic problems was conducted by the medical service of the Memorial Hospital. It was largely attended by the staff but in particular, there was a large attendance of non-members of the staff from the profession in the Blackstone Valley. The important features brought out at the conference were the care of the comatose patient, proper care of the diabetic on leaving the institution and the care of the diabetic with such surgical complications as carbuncle, gangrene of the feet and abdominal operations such as an appendectomy. A request for another Round Table in the future was made by a number of the medical men in the Blackstone Valley.

Dr. and Mrs. Jesse P. Eddy, 3rd, are to be congratulated on the birth of a second daughter.

Dr. and Mrs. Francis E. Hanley are to be congratulated on the birth of a daughter.

St. Joseph's Hospital

The Annual Outing and Dinner of St. Joseph's Hospital Staff Association was held on June 16, 1937, at the Metacomet Country Club in East Providence, Rhode Island. There were about One Hundred members and guests present. Among the guests were The Most Reverend Francis P. Keough, D.D., Bishop of Providence; Right Reverend Peter E. Blessing, D.D., V.G., and Reverend Thomas C. Collins, representatives of the Hospital Corporation. The afternoon was given over to field sports and golfing, in which a large number of the members participated. There were prizes awarded to the successful entrants in these sports. In the evening, dinner was served at the Club with President Edward F. Burke presiding and Dr. William R. McGuirk toastmaster. Both the Most Reverend Bishop and the Right Reverend Monsignor addressed the gathering. Following the dinner, there was entertainment. Arrangements were in charge of President Edward F. Burke, James H. Fagan and Vincent J. Ryan.

Edwin B. O'Reilly, M.D., C.M., of North Providence, Rhode Island, completed a two year rotating internship at St. Joseph's Hospital on June 30, 1937. He graduated from McGill University Faculty of Medicine, Montreal, Canada, in 1935. Dr. O'Reilly's office will be located at 873 Smith Street, Providence, Rhode Island, after August 1, 1937.

H. Paul Narcessian, D.M.D., of Woonsocket, Rhode Island, completed a one year dental internship at St. Joseph's Hospital, June 30, 1937. He graduated from Tufts Dental College in 1936. He will open an office in Providence sometime in September, 1937.

Stephen Fortunato, M.D., Wilmington, Del., began a two year rotating internship at St. Joseph's Hospital. He graduated from the University of Virginia in June, 1937.

Thomas Anthony Egan, M.D., 154 Francis Street, Providence, Rhode Island, was married in June to Miss Charlotte E. Wendelowski, Floral Park, Long Island, New York. Mrs. Egan is a graduate of St. Catherine's Hospital School for Nurses in Brooklyn.

James J. Flanagan, M.D., 25 Warwick Avenue, Cranston, was married to Miss Loretto Schwartz, of Washington, D. C., on June 15, 1937.

Dr. William Casey, 218 Garden Street, Pawtucket, Rhode Island, began a one year dental internship at St. Joseph's Hospital on July 1, 1937. He graduated from the University of Maryland Dental School in June, 1937.

OBITUARY

EDGAR B. SMITH, M.D., F.A.C.S.

Dr. Edgar Bronson Smith, a leading physician and surgeon of Providence for more than half a century, died suddenly in his bed, of coronary occlusion, in Orlando, Fla., on April 9, 1937. He was on his way to Providence from Clearwater, Fla., where, with his wife, he had spent the winter in the enjoyment of good health.

Dr. Smith was in his eighty-fourth year, having been born in Winsted, Conn., Dec. 23, 1853, the son of Jesse and Jane P. (Bradford) Smith, and came to Forestdale, R. I., with his parents in early boyhood. He prepared for college in Lapham Institute, North Scituate, and entered Brown University with the class of 1878. After a two years' premedical course there,(he entered the College of Physicians and Surgeons in Columbia University, obtaining his M.D. degree in 1880. In 1909, by special vote of the Brown University Corporation, he was given his Ph.B. degree and enrolled with the class of 1878. Following completion of his medical studies at Columbia, he returned to Rhode Island to set up a general practice in Providence, but it was not long before he confined himself principally, and later exclusively, to surgery.

Dr. Smith had been visiting surgeon at the Rhode Island Hospital since 1897 and similarly connected with St. Joseph's Hospital from 1898 to 1901. He had also been, up to the time of his death, consulting surgeon to various hospitals in the State, including Butler Hospital.

Dr. Smith was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, the American College of Surgeons, the New England Surgical Society, the American Urological Society, the Providence Chemical Club and the Friday Evening Medical Club.

He was married October 12, 1881, to Evelyn O. Bates of this city, who died many years ago. His second wife, Mrs. Harriet Lindsay Smith, whom he married in 1925, is his only survivor.

In the passing of Edgar Bronson Smith, the medical profession of Rhode Island has lost one of its outstanding and most loved members. Not only was he a skillful surgeon who devoted himself without stint to his patients, but a man of the highest character who had endeared himself to the whole people by the charm of his personality. To him might fitly be applied the encomium of our Quaker poet:

> A true and brave and downright honest man;
> Loathing pretense, he did with cheerful will
> What others talked of while their hands were still.

To a bedside he always brought the comfort of a wise, serene and understanding presence; and, figuratively, he was ever busy lighting fires in rooms that called for such warmth and cheer as it might be in his power to produce.

In its sorrowing, this Society remembers these things and much else, and is itself comforted in bereavement.

G. Alder Blumer, M.D.
Lucius C. Kingman, M.D.

FRANK JOSEPH JONES, M.D.

Dr. Frank Joseph Jones died in this city on December 17, 1936, after an illness of 21 months duration. Respected and admired by a host of grateful patients and loyal friends, his passing is mourned by these and countless others who sought his advice, ministrations and friendship. Dr. Jones was born in Worcester, Mass., January 15, 1877, the son of Daniel and Winifred Dolan Jones. He attended public schools. Pursuing his medical course at Harvard Medical School, he was graduated therefrom in 1901 and interned at St. Joseph's Hospital, this city, from 1901 to 1902. He entered practice in this city, settling on Douglas Avenue for the first five years thereof, later moving to Orms Street and finally established himself on Francis Street in 1909, where he remained until illness necessitated retirement from practice, early in March, 1935. He is survived by his wife, Mrs. Alice Kelly Jones and two sons, Frank J., Jr., and Charles, both of whom are teachers in the regional high schools in this city.

Dr. Jones developed a large practice and while never actually specializing devoted a good deal of

attention to obstetrics. He served on the staff of St. Joseph's Hospital as Obstetrician and Assistant Gynecologist for many years. But the chief factor in his establishment was his kindly, sympathetic nature, readily accessible at all times, responsive to all demands, and available for any service. He was really typical of the family doctor one hears so much about in fiction and so little about in real life. These qualities made Dr. Jones so much more desirable as friend, counselor, and intimate adviser. Never spectacular nor dominating, his influence was nevertheless impressed upon those who availed themselves of his services, advice and friendship. To know him was to appreciate those qualities so much to be desired in the daily conduct of a busy practice. He will be missed by a large circle of friends and colleagues but particularly by those of us who were associated with him and bound to him by ties of intimate friendship, and the memory of this steady and constant devotee to the highest ideals of his calling shall serve as an inspiration for many years to come.

Joseph L. Belliotti, M.D.,
John J. Kenney, M.D.

RECENT BOOKS

Diabetes, A Modern Manual. By Anthony M. Sindoni, Jr., M.D. With an Introduction by Morris Fishbein, M.D., and a Foreword by George Morris Piersol, B.S., M.D. pp. 240. Cloth, $2.00, Whittlesey House, McGraw Hill Book Company, Inc., 330 West 42nd Street, New York City, 1937.

This hand-book for the use of patients with diabetes is an excellent example of what a work of this sort should be. It is very clearly written in a style so simple and straightforward that it should be of great value as a guide to any diabetic of average intelligence and ability to read. While there is a great deal of detailed information presented it is done in such a way that the reader is not likely to be confused and the things which are important are easily recognized as such.

The book is divided in three sections. "Questions asked the Physician" is the first. In this are presented in the form of questions and answers most of the material about which a diabetic needs to inquire. The second section, "What to Know," is a very excellent summary of necessary and practical knowledge, with illustrations, diagrams and tables that are helpful and not confusing. "What to Do," the final part of the book, is a very practical discussion of how to act in the various emergencies that may arise, e. g., acidosis and coma, insulin "shock" etc.; and it also includes a discussion of routine activities such as food calculation, exercise, the care of the feet, eyes, bowels, urine testing and so forth. The discussion of general hygiene, the presentation of the methods of food calculation and the section on the care of the feet seem to this reviewer to be especially commendable.

Of course there are a few points on which most internists who are interested in diabetes may differ with the author. It seems to the reviewer that the time recommended for giving insulin (15 or 20 minutes after meals) will find little support among medical men. The locations on the body surface advised for injections are not the sites usually selected. The description of insulin shock in the question and answer section seems quite inadequate, but this is remedied in the fuller description given under "What to Know." On page 187 in the discussion of the treatment of coma in adults no mention is made of giving carbohydrates by mouth. The discussion of Protamine Zinc Insulin is good but, as the author intimates, will require revision very soon as our knowledge of the proper use of this preparation increases.

On the whole it may be said that the flaws that one may detect in the work are insignificant and that the book is deserving of very high praise and can be recommended to the diabetic public (as well as to the general practitioner who wishes to brush up his knowledge of the subject and treat his patients adequately) without reserve.

Alex. M. Burgess, M.D.

Physical Diagnosis, The Art and Technique of History Taking and Physical Examination of the Patient in Health and in Disease. By Don C. Sutton, M.S., M.D. With 298 Text Illustrations and 8 Color Plates. The C. V. Mosby Co. St. Louis, 1937.

The value of the direct examination of the patient can never be emphasized too strongly. Hence the need of a new approach to the subject is ever present. In this effort, the author has used a few innovations. The most notable is the inclusion of a chapter giving an historical outline of the development of physical diagnosis. Although sketchy, yet it is successful, for it tends to make the reader seek the original work for further details. The subject matter itself is divided up into the examination of the various body parts. The many signs are well described, and the differential diagnosis is on the whole well done. A brief description of the anatomy concerned is also included and this proves to be very helpful. The author in his differential diagnosis is apt to stay afield, however, in giving data that to the reviewer appears irrevelant and unnecessary. For example, in a book of physical diagnosis, there is little need to use eight pages in a discussion of electrocardiographic findings, to give a discussion of X-ray evidence of gastric disease or to give details of procedure in passing a stomach tube, or doing a lumbar puncture. Also his reviewing of diseases is apt to be sketchy and confusing to the reader's mind, rather than instructive. The terminology is generally correct. It is rather amazing, therefore, to find arteriosclerotic heart disease called chronic myocarditis—a phrase that has been declared incorrect for several years. The book is supplied generously with photographs and drawings. The anatomical illustrations are particularly good, honorable

mention being given those of coronal sections. On the other hand to the reviewer, the photographs seemed to be below average. They are not clearly reproduced, and therefore do not demonstrate at all well what the author intends to bring out. They are often strikingly familiar, having appeared in other books before, and carry a quaint old-fashioned character to them. And lastly they are not always germain to the subject up for discussion. This is particularly true in some of the X-rays of conditions that cannot be diagnosed by physical findings, and only seem to be included through general medical interest. The reviewer feels that while there are some excellent points to this book, on the whole better ones are available.

Francis H. Chaffee, M.D.

An Introduction to Medical Science. By William Boyd, M.D., M.R.C.P. (Edin.), F.R.C.P. (Lond.), Dipl. Psych., F.R.S. (Canada). Octavo, pp. 307. Illustrated with 108 engravings. Cloth, $3.50 net. Philadelphia, Lea & Febiger, 1937.

The author of this manual requires no introduction. His former authoritative publications have been well received by the Medical Profession. This recent work is really an introduction to Medical Science, and therefore will be of little interest to the physician. However, as an elementary text it will find favor with the student nurse, the pre-medical student, or with the intelligent layman who occasionally becomes "medically minded."

In this book the reader will find a brief but comprehensive survey of disease. The subjects for discussion have been carefully selected, clearly presented, and well illustrated. The nature of the disease process and the relationship between the pathological lesion and the presenting symptoms has been adequately discussed.

Altogether the reviewer found this small volume to be a well written and instructive outline of disease. Offered as an introductory work, it should find considerable favor with those for whom it was intended.

Russell S. Bray, M.D.

The Intimate Side of a Woman's Life. By Leona W. Chalmers. With a Foreword by Winfield Scott Pugh, M.D. pp. 128. Cloth, $1.50. New York, Pioneer Publications, Inc., Radio City, 1937.

This is a non-medical book written by a woman for the edification of women as to their pelvic anatomy and the disturbances that commonly cause trouble therewith. The writer has given chapters as to the anatomy, the common displacements of the pelvic organs and has then discussed the common gynecological symptoms of constipation, leucorrhoea, and menstrual pain.

She has then devoted a chapter to vaginal hygiene and has taken the position that the vagina is a septic cavity which if not thoroughly and painstakingly douched at regular intervals is a breeder of disease and of invalidism. She has shown us various methods of douching, including the most favorable positions and the best type of instruments to use. She has rightly pointed out that most vaginal discharges come from an infected cervix and that there are no glands in the uterine wall which might cause disturbance but that this vaginal wall is drawn into folds and crypts which, unless they are fully distended and washed out, form the lurking places for germs. To overcome this she would overdistend the vagina with her douche solution and thereby get her solution in contact with the depths of the mucosa between the folds. She feels that as with the vagina so with the other body cavities, the mouth, the nose, great care, washing should be carried on.

This is a book that will interest women. It may do some good. One cannot help feel that her method of douching is not a little liable to force the solution up into the uterine cavity and out through the tubes and may not be on that account entirely innocuous. One would also feel that in the presence of a vaginal discharge it were better to consult a competent gynecologist and have the source of the discharge cleared up. We are not yet ready to concede that the vaginal walls are not capable of caring for themselves. It is now known that there is a cycle of the vaginal epithelium which corresponds to that found in the cervix and in the endometrium, and that the acidity of the vagina is in some way dependent on the changes in the vaginal wall and their effect on the vaginal flora. If this is true, is it any more sense to be constantly lavaging and douching out the vagina than to keep constantly gargling or spraying the throat or washing out the nose, all of which procedures are not in favor among good nose and throat people.

In that this book may call attention to women that vaginal discharges are not normal, and get them to consult their doctor, it probably is excellent. We still think that the medical profession is the best judge of how to take a douche and when to take a douche.

George W. Waterman, M.D.

The Nutritive Value of Canned Foods. Compiled by the Nutrition Laboratory, Research Department of the American Can Company. pp. 110, with 10 illustrations and 8 plates. American Can Company, New York, 1937.

The book is a general summary of facts about tin containers and canned foods. It is divided into two sections. The first deals with the preservation of foods, dietary requirements, the mineral and vitamin conservation in canned foods, infant nutrition, and the safety of canned foods under modern methods of packing. Section two takes up the manufacture of the cans, including the tin-plating, enameling, and a description of can sizes. It also discusses the canning procedure from the raw materials through the sealing of the cans and the heat processing.

The back of the book contains an appendix of reference tables of all kinds. There are charts on human energy expenditures, dietary requirements, mineral and iodine content of various foods, and analyses of canned foods of many kinds. A bibliography contains an appendix of references to the more complete works on each phase of the industry as well as the general texts used in preparation of the book.



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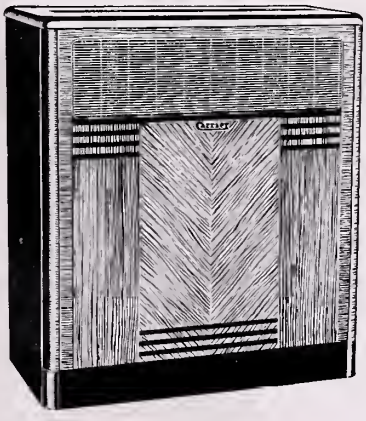
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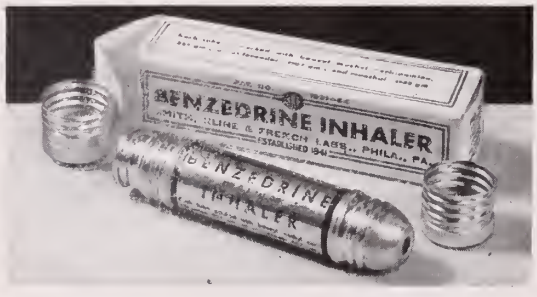


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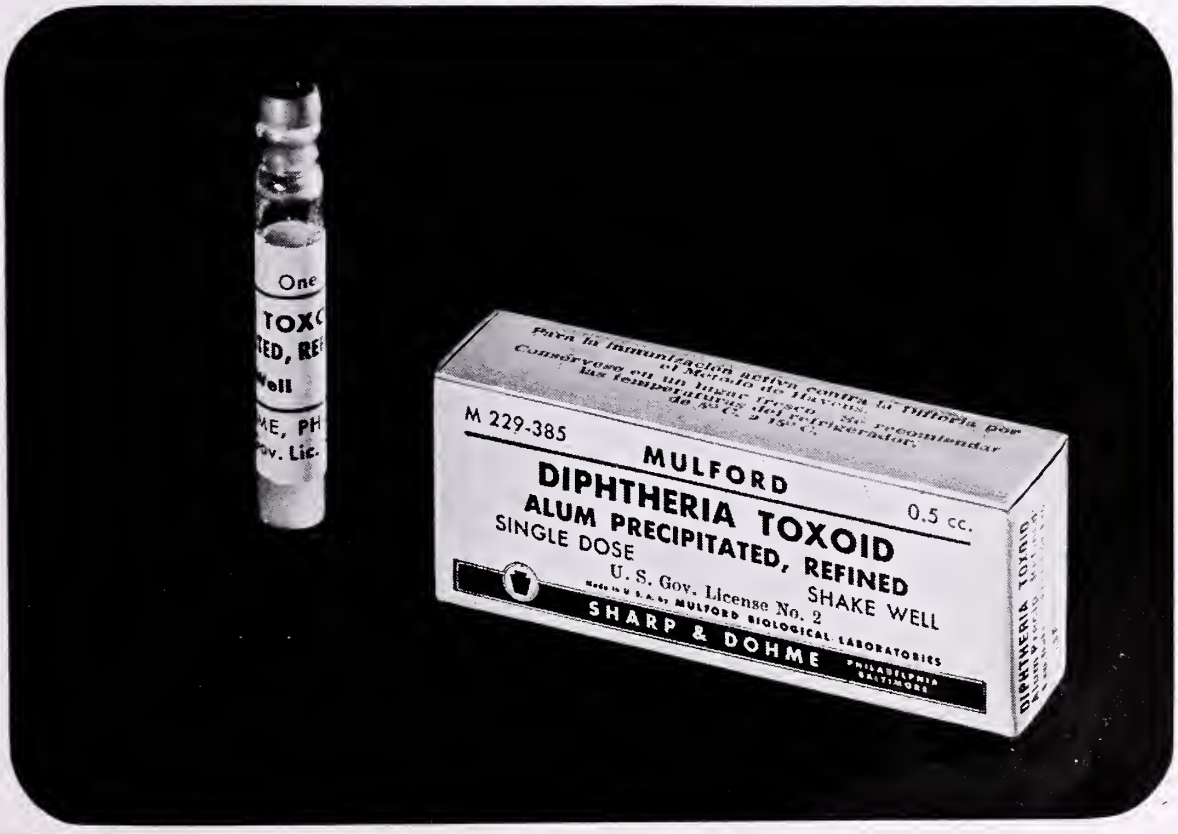
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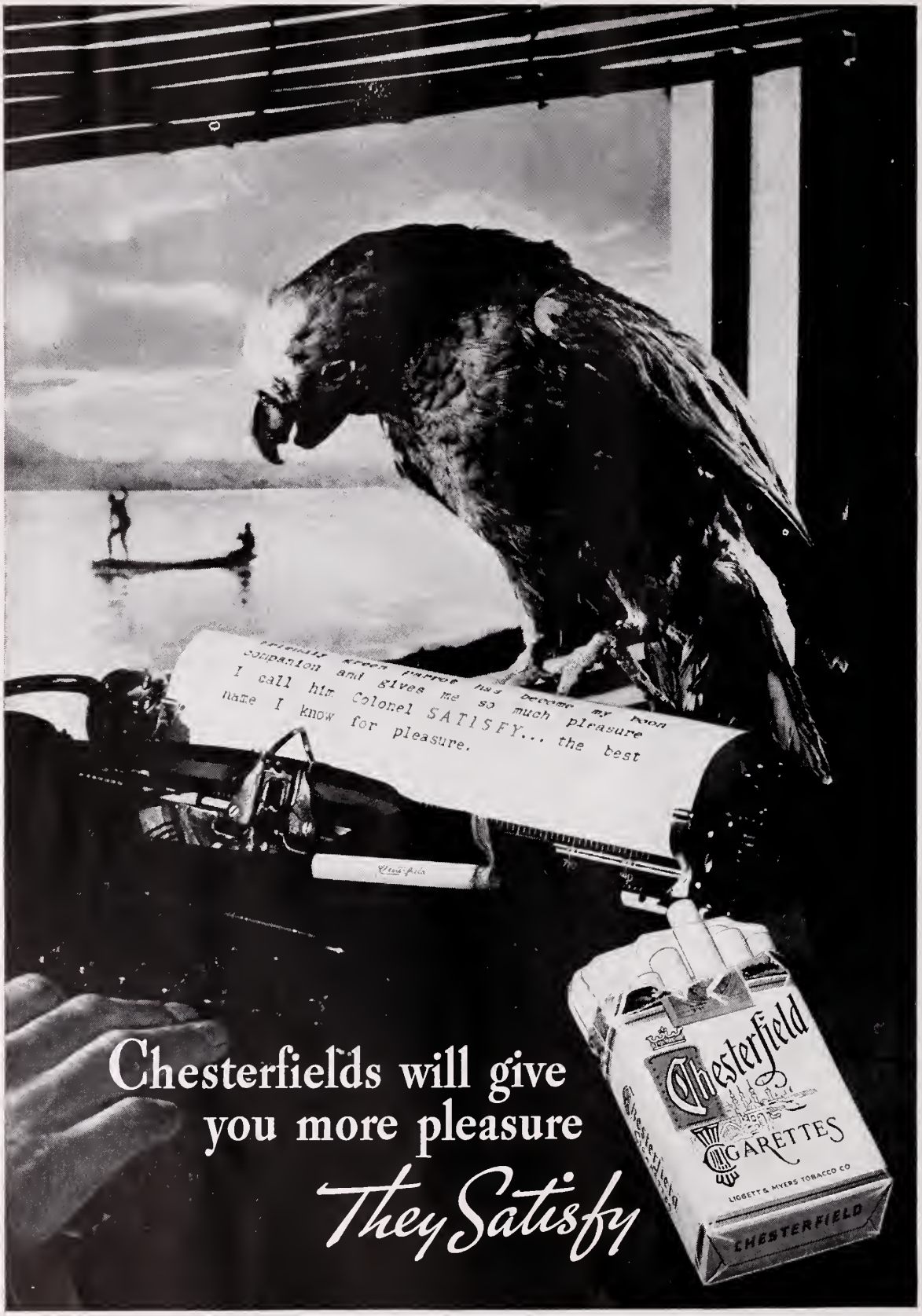
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THE RHODE ISLAND MEDICAL JOURNAL

Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 9
Whole No. 336
SEPTEMBER, 1937
PER YEAR $2.00
SINGLE COPY 25 CENTS

ROCKY MOUNTAIN SPOTTED FEVER IN RHODE ISLAND

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RHODE ISLAND DEPARTMENT OF PUBLIC HEALTH

Of unusual academic interest and considerable epidemiological significance is the appearance of two cases of Rocky Mountain Spotted Fever in Rhode Island. The diagnosis of the two cases has been confirmed clinically and serologically. Both cases have been hospitalized at the Charles V. Chapin Hospital. According to information received at the Bureau of Preventable Diseases, Rhode Island Department of Public Health, these are the first instances of the disease in New England. Investigation shows that the onset of the disease in both cases followed tick bites received while the patients were summer visitors in East Brewster, Massachusetts. The case reports are as follows:

CASE 1. H. D., age forty-nine, white, married, native born and a police officer by occupation. Was admitted to the Charles V. Chapin Hospital on July 26, 1937 with the chief complaint: headache, abdominal pain and persistent constipation for six days prior to the hospital admission.

On July 8, 1937, the patient accompanied by his wife went for a vacation to the town of East Brewster on Cape Cod, Massachusetts. The house at which they stayed was unoccupied by any other person during the visit. There were no cats, dogs or other animals on the premises. Neither were there any signs of rats or mice in the immediate vicinity of the house. While staying here the patient and his wife visited a private beach, owned by the proprietor of the house, practically every day. Wood ticks were present in abundance in the grass and scrub growth about this beach.

On July 15th or 16th while lying on the beach in a bathing suit the patient received a tick bite on his left forearm. This was the only tick bite recalled by him. He had no recollection of the length of time the tick had been attached to his forearm. At first he thought it to be a "scab" and picked it off with some difficulty. After picking it off he killed it by squeezing it sideways between his fingers. The bite did not become infected. During the next few days he felt "dopey" and "lacking in pep."

On July 20th toward the end of the afternoon the patient was seized suddenly with a frontal headache and his abdomen felt as though it were "blown up like a balloon" and "tender all over." He felt general aches and pains in the back and legs. Loss of appetite was marked and there was some nausea but no vomiting. For over a week following the onset of these symptoms the patient did not take any solid food.

On the night of July 20th he had a chill which was followed by profuse sweating.

On July 21st he felt restless and was in and out of bed all during the day. In the morning he noticed for the first time a rash which already had covered his entire body from the neck down. The bowels did not move and the abdominal distention continued. Chills followed by profuse sweating continued.

On July 23rd his condition being unchanged, patient and his wife were driven back to Providence in an automobile by his son. At this time he felt very dry and thirsty and drank a great deal of water.

On his return to Providence he was seen by one of us (E. A. McL.). An enema was given which partly released the abdominal distention but produced little fecal result. Previous to the present illness the patient was inclined to be constipated and maintained some degree of regularity of the bowels with the use of Sal Hepatica. Since the onset of the present illness no cathartics had been taken and the bowels did not move for six days.

On the afternoon of July 23rd temperature was 102 degrees F. For the next day there was little change except that patient vomited once during the afternoon. Temperature remained at 102 degrees.

On July 26th prior to his admission to the Charles V. Chapin Hospital temperature rose to 103 degrees. The throbbing headache and constipation had steadily increased and there was considerable malaise and the patient complained of insomnia. There had been a slight cough with pro-

duction of a whitish phlegm. There had been pains in the left upper quadrant along with the feeling of abdominal distention.

He stated that he had not eaten shellfish of any kind. In Providence he was in the habit of drinking water only from the city supply. In East Brewster he drank water from an artesian well. He used only pasteurized milk and had not wittingly been in contact with typhoid carriers. The family history, marital history and social history were negative.

Past History

Measles in childhood.
Diphtheria in 1920.
Quinsy sore throat in 1921.
Motor vehicle accident in 1921 in which he suffered broken bones in his left hand and left foot. Great toe of the left foot amputated.
Tonsillectomy in 1921.

Physical examination on admission showed the entire body from the neck down to be covered with a discrete reddish macular-papular eruption. Some of these lesions were barely palpable; others were not. Some blanched with pressure; others did not. The distribution was fairly uniform on the flexor and extensor surfaces and on the trunk and extremities. The lungs showed a few fine rales in the bases. The abdomen was distended with gas. The liver and spleen were not felt but tenderness was elicited over the splenic region. There was no costovertebral tenderness. The tentative diagnosis on admission was (?) typhoid fever.

Laboratory Studies

Urinalyses in four examinations, July 27th to 30th, showed albumen slight trace on two occasions. Frequent red blood cells and white blood cells on one occasion. Rare red blood cells and rare hyaline and granular casts on one occasion.

Cultures for typhoid and dysentery were negative.

Spinal fluid studies essentially negative.

Wassermann and Hinton negative.

Repeated blood cultures were sterile.

Blood picture on July 26, 1937

Hemoglobin	85 (Tallquist)
Red blood cells	5,160,000
White blood cells	11,550
Polymorphonuclears	75%
Lymphocytes	20%
Monocytes	5%

Widal for typhoid and paratyphoid negative.
On July 26th by rapid slide negative.
Undulant fever (Huddleston) negative on July 26th.
Blood chemistry on July 26th.
150 sugar
39 N. P. N.

Stools on three examinations were negative for typhoid and paratyphoid bacilli.

Nose and throat cultures were negative.

Skin test on August 3rd negative for undulant fever.

Blood picture on August 6th

White blood cells	8,200
Polymorphonuclears	44%
Lymphocytes	49%
Monocytes	5%
Eosinophiles	2%

Weil-Felix Reaction

Prior to the hospital admission on July 26th and at the request of the Department of Public Health, a sample of blood was obtained and sent to the Conn. State Health Laboratories for consideration of Rocky Mountain spotted fever or typhus fever as possibilities.

1. Connecticut State Department of Health Bureau of Laboratories. July 26th.
   3 plus agglutination in dilutions 1:20 and 1:40
   2 plus in 1:80 dilution
   1 plus in 1:160 dilution
   ± in 1:320 dilution
2. Harvard University Medical School Department of Bacteriology and Immunology (Dr. Zinsser). August 4th.
   Agglutination in 1:2500 dilution with OX19
   In 1:320 with proteus OXK
3. U. S. Public Health Service. August 11th. National Institute of Health (Dr. R. E. Dyer).
   Agglutination in 1:25,560 dilution with proteus OX19

On August 10, 1937, Dr. Hans Zinsser of Harvard Medical School visited the patient and stated that in his opinion the case belonged to the Rocky Mountain Spotted Fever group of diseases, rather than typhus fever.

Course in Hospital

On admission the temperature was 102 degrees F., pulse 100, respiration 30. Temperature exhibited morning remission and evening exacerba-

tion. Normal on August 5th, remaining normal since that date.

At this time (August 17, 1937) the eruption is still found to persist with characteristic appearance about the ankles and feet.

CASE 2, WIFE OF CASE 1

Admitted to the Charles V. Chapin Hospital on July 31st for observation. On admission she had a temperature of 102.4 degrees F., pulse 130, respiration 20. Chief complaint: headache and generalized eruption of four days duration. She was assertedly in good health until July 18th, when she was bitten by a wood tick while spending her vacation in East Brewster. The tick had attached itself to a toe on her right foot and had remained there for several days before being pulled off with difficulty.

On July 24th while caring for her sick husband she began to have generalized malaise and fatigue.

On July 27th she developed a severe frontal headache and a generalized rash over the body from the neck down. The rash was similar in distribution and appearance to that of her husband, whose rash had developed about one week earlier. Since the onset of her illness fever had been as high as 104 degrees. The patient recalls that the tick bite on a toe of her right foot had become infected. There were no other symptoms except for a "running" and partially obstructed nose accompanied by a slight sore throat. There were no gastrointestinal or genito-urinary systems. Generalized aches and pains were present, particularly, over the small of her back.

Past History

Diphtheria and scarlet fever.

On admission patient presented a macular-papular reddish eruption over the body. The lesions were discrete, the average size being approximately one half a centimeter in diameter. There were comparatively few lesions on the trunk. The elbows and knees were mostly affected. There were some lesions on the palms and soles. All lesions blanched with pressure. The flexor and extensor surfaces were equally affected. There was a soft systolic murmur at the apex of the heart. The extremities were normal except for a crust at the site of the tick bite on a toe of the right foot.

Laboratory Findings

Blood cultures while at the hospital repeatedly negative.

Urine has been negative.

Blood Widal rapid slide agglutination test on August 6th showed positive with typhoid "0" in 1:20 dilution and weakly positive in 1:40 dilution.

Blood serology for Undulant fever showed 1:25 dilution weakly positive and 1:50 dilution very weakly positive. 1:100 negative 1:200 negative.

Wassermann and Hinton test negative.

Skin test for undulant fever on August 3rd (?) slightly positive.

Weil-Felix Reaction

1. Harvard Medical School
   Department of Bacteriology and Immunology (Dr. Zinsser)
   August 4th. Weil Felix Reaction Positive in 1:320 dilution with Proteus OX19 and OXK.
2. U. S. Public Health Service
   National Institute of Health (Dr. Dyer)
   Positive in 1:2500 dilution. August 10th. The strains used were B. proteus OX19 and OXK.

In the opinion of the National Institute of Health the history, clinical findings and laboratory results were consistent with a diagnosis of Rocky Mountain spotted fever.

During the week of August 16th, with the cooperation of the local board of health in East Brewster, Massachusetts, three ticks were collected and sent to Dr. Zinsser's laboratory at the Harvard Medical School. These ticks were identified by the state entomologist as *Dermacentor variabilis*.

Comment

Several interesting points have been brought up in connection with these reported cases. Communications with the state health officers of the New England states, and with Dr. Hans Zinsser of the Harvard Medical School and Dr. R. E. Dyer of the U. S. Public Health Service have indicated that these are the first definite cases of Rocky Mountain spotted fever to be reported in New England. The clinical pictures and laboratory findings have been entirely consistent with the diagnosis. The history of tick bites, incubation period and symptomatology are in complete accord with our knowledge of the disease. Many interesting channels of speculation are present with reference to the occurrence of these cases. Why should the disease have singled out two out-of-state summer visitors? Careful questioning of neighbors in the community reveals that tick bites are quite common in the locality yet

no cases of the disease had ever been reported in the past. Is it possible that infective ticks have been brought into the locality from residents in other sections of the country? Perhaps through the medium of tourists or animals? Could native ticks have been infected through contact with persons from other states where the disease is prevalent? It is known that about the time of the probable infection in the two cases, a number of boys from states in which the disease has been reported, were spending their summer at a private camp located about one quarter of a mile from the house and beach used by the cases. These and other questions remain to be answered.

*A brief review of the history of Rocky Mountain spotted fever shows that it was known to have occurred among white people of the Rocky Mountain region in Montana and Idaho as early as 1885. It is quite probable that the disease existed among Indians before that time but accurate data on that point are not available. It had been observed that the disease occurred during the season of greatest prevalence of wood tick. The disease has occurred more commonly among those whose occupation exposed them to the bites of ticks and in the majority of cases the history of tick bite was obtainable. In 1906 Ricketts began studies which demonstrated the presence of infected wood ticks in nature and the hereditary passage of the virus from one generation of the tick to the next. King and Ricketts independently were successful in transmitting spotted fever to guinea pigs by the bite of ticks. Since that time it has been found that several of the species of ticks found in this country are capable of transmitting the disease.

In 1908 the distribution of Spotted Fever as known in the United States included the states of Idaho, Missouri, Wyoming, Nevada, Oregon, California, Washington, Colorado and Utah. It was noted at that time that the disease was rather sharply localized in certain small areas in the Northwestern states. This same tendency to localization in fairly well circumscribed areas has apparently remained as an epidemiological characteristic of the disease to this day.

In the twenty years following 1908 cases of the disease were also recognized in South Dakota and North Dakota. One case was reported in Indiana in 1925. A case was reported in New York in 1925 and the diagnosis of Spotted Fever considered. This diagnosis was ruled out largely on the ground that spotted fever had been reported only from a limited locality. Spencer reported a case of typhus-like fever following tick bite which occurred in Norfolk, Virginia, in 1926. It would appear in the light of our present knowledge, that the New York case and the Norfolk case were both spotted fever.

At this point it might be of interest to state that cases of typhus-like fevers occurring in the Eastern states could be divided into two groups epidemiologically. One group was predominantly an urban disease of urban origin. The second group comprised those cases of Rocky Mountain spotted fever which were rural in origin. These latter cases in an significantly high percentage followed a tick bite after a short period of incubation.

Many observers have noted that the season of incidence of the rural cases corresponds closely to the presence of a common tick in the region where the cases occurred.

The tick *Dermacentor variabilis* is closely related to the tick responsible for the Northwestern cases of spotted fever.

Blood drawn from the spotted fever-like cases in the East and injected into laboratory animals produced a disease in these animals which was found by Badger of the U. S. Public Health Service to be identical with spotted fever in all particulars save for the absence of scrotal inflammation in male guinea pigs.

The Eastern strains of spotted fever like the Western strains do not immunize against typhus fever.

It has already been pointed out that incidence of spotted fever in the West and in the East corresponds to the tick season in the two sections. In the East *Dermacentor variabilis* appear in March and are more prevalent from the middle of May to the middle of July. Occasionally they are found as late as October or November. Spotted fever in man in the East has been reported from March to December with the greatest incidence in June and July. The Eastern states which have reported cases of spotted fever prior to the Rhode Island cases are New York, Pennsylvania, Maryland, Virginia, Delaware, New Jersey, North Carolina, South Carolina, Georgia, Tennessee, Texas, Louisiana and Oklahoma and the District of Columbia.

*From the Kober Lecture for 1933.
By R. E. Dyer, Surgeon, U.S.P.H.S.
Subject: Typhus and Rocky Mountain Spotted Fever in the United States "Military Surgeon" June, 1933.

Studies of the serum from our own reported cases are being conducted in the laboratory of Dr. Hans Zinsser of the Harvard Medical School. Department of Bacteriology and Immunology and at the National Institute of Health of the U. S. Public Health Service.

In addition, Dr. Zinsser will conduct studies in ticks collected in the neighborhood of the camp in Brewster, Massachusetts, in an effort to get a virus. Also, an investigation will be made for rat infestation in the vicinity. Rats will be trapped in an effort to collect fleas and studies of these insects will be made for determining the presence of virus. The studies of Marshall Hertig and his co-workers at the Harvard Medical School have shown that the meadow mouse commonly found on Cape Cod, Nantucket and Martha's Vineyard, serves as a reservoir host for larva, or "seed tick," and nymph stages of the *Dermacentor Variabilis*. Consequently this rodent will also be trapped in an attempt to isolate the virus from these young stages of the insect.

The annual Clinical Congress of the Connecticut State Medical Society which was attended last year by 633 physicians from ten states will be held this year in New Haven on Tuesday, Wednesday and Thursday, September 21, 22, 23. The registration fee for the entire Congress will be $2.00. The morning sessions beginning at 9:30, will be held in the auditorium of the Sterling Law Buildings. The afternoon and evening sessions, beginning at 2:15 and 8:15 respectively, will be held in the buildings of the New Haven Hospital and the Yale School of Medicine. The evening meetings are section meetings which are open to all members of the Congress.

Complete program and registration card can be obtained from the Chairman of the Committee on Publicity and Registration, Dr. Maurice J. Strauss, 41 Trumbull Street, New Haven, Connecticut.

The Fifteenth Annual Meeting of the Academy of Physical Medicine will be held at the Hotel Walton, Philadelphia, October 19, 20, 21, 1937.

A copy of the program may be had by addressing:

William D. McFee, M.D., *Chairman*
Committee on Program and Publication,
41 Bay State Road, Boston, Mass.

AFFECTIONS OF THE COLON, THEIR CLASSIFICATION AND DESCRIPTION

Charles W. McClure, M.D., and
John Zielinski, M.D.

406 Marlborough Street, Boston, Mass.

Today it is my purpose to attempt to present my conception of the clinical entities affecting the large bowel. In this attempt I shall first outline the clinically important affections in the following charts. Then brief descriptions of these important clinical entities will be given.

Primary Diseases of Colon

Diverticulosis and -itis
Polyposis
    Congenital
    Acquired
Carcinoma
    Right colon
    Left colon
Colitides
Fistula
Megacolon
Sarcoma
Benign tumors
Granuloma
    Specific: lues, tbc., actinomycosis
    Non-specific:
Parasitic infestations
    Amoeba, giardia, tapeworm
Bacillary dysenteries
Volvulus
Intussusception
Appendicitis
Appendices epiploicae; affections

Secondary Disorders of Colon

Functional origin
    Spastic colon
    Atonic colon
    fecal impaction
    constipation
Irritable bowel

Read before the Rhode Island Medical Society at the One Hundred and Twenty-sixth Annual Meeting, Providence, June 2-3, 1937.

Charles W. McClure, M.D., Gastroenterologist to the Fifth Medical Service and Junior Visiting Physician, Boston City Hospital. Assistant Professor of Gastroenterology, Boston University School of Medicine.

John Zielinski, M.D., Resident Radiographer, Boston City Hospital.

Disorders of the Rectum

Strictures, new growths, polyps, prolapse, ulcerations, inflammations, foreign bodies, lymphopathia venerea.

Disorders of Anus

Infections, spasm, fissure, ulcer, stricture, anal eczema and pruritus ani, hemorrhoids, fistula, syphilis.

Diverticulosis and Diverticulitis:—Diverticulosis is the result of evaginations, out-pouchings, of the wall of the colon forming sacculations. These saccules vary in number and size; their average diameter is about a centimeter. 80% of diverticula occur in the sigmoid. They are most common after the age of 40, and 70% of them occur between the ages of 50 and 70. The demonstration of the presence of diverticula depends on the x-ray. Their presence is an indication for a bland diet, mineral oil and avoidance of cathartics and enemata.

Diverticula become of clinical significance in about 1/5 of the cases because they become inflamed. The resulting diverticulitis may be acute or chronic. Since both a diverticulum and the appendix are sacculations, the symptoms of inflammation of either are similar. A salient differential diagnostic feature is that diverticulitis usually occurs in the sigmoid and therefore the symptoms are most frequently localized in the left lower quadrant. Also, as in appendicitis, the symptoms of diverticulitis vary from mild to very stormy. There may be merely discomfort; or there may be sharp pain, localized tenderness and muscular rigidity, fever, leucocytosis, nausea and vomiting.

The treatment of diverticulitis is expectant; i.e., you expect the patient under rest in bed to get better or worse. If he gets worse it is usually due to (1) acute perforation, (2) abscess formation, (3) fistula formation either vesical or intestinal, or perhaps external, and single or multiple in number, (4) inflammatory obstruction, or (5) malignant degeneration.

Polyposis:—In addition to true polyps small benign growths such as adenomas, papillomas, fibromas etc., which project into the lumen of the bowel are loosely called polyps. Polyps are either congenital or acquired. The acquired result from some inflammatory process and are especially common in odd cases of ulcerative colitis. Multiple polyposis, or more correctly diffuse adenomatosis, of congenital origin is found in adults most frequently between 30 and 40 years of age. Carcinoma eventually develops in about 50% of these cases. Multiple polyposis (polypoidosis) gives rise to colicky abdominal pain and diarrhoea and the stools may contain bloody mucous. In such cases loss of strength and weight are common; while anorexia, nausea and vomiting are occasionally present. Complications which occur are ulceration, intestinal obstruction, intussusception, secondary anemia and malignant degeneration.

The diagnosis of diffuse adenomatosis of the rectum is readily made by a digital rectal examination. However, the most effective means of finding polyps in the rectum or sigmoid is by means of the sigmoidoscope. The demonstration of polyps in other parts of the bowel depends on special x-ray technic. "The frequency with which single or multiple polyps are found in the colon and rectum is in direct proportion to the care and assiduity with which one seeks them."

It is wisest to consider all polyps, whether true or false or single or multiple, as potentially malignant. Thus the treatment is always surgical.

Cancer of the Colon:—Cancer of the colon presents variable clinical pictures because of differences in the physiology and pathology of the right and left halves of the colon. The function of the right colon is absorption, the feces are liquid, the cancers are of the raw surface, ulcerating, medullary type and the symptoms are essentially toxic. The function of the left colon is excretory, the feces are solid, the cancers are of the scirrhous type and the symptoms are essentially obstructive.

The toxic symptoms of cancer of the right colon may be briefly grouped as follows—(1) irritable colon; (2) pain or distress resembling (a) acute, subacute or chronic appendicitis, (b) gall bladder disease, or (c) atypical peptic ulcer; (3) profound secondary anemia. A palpable mass in right lower quadrant is often found accidentally by the patient or the examining physician.

The obstructive symptoms of the left colon may be acute; when due to foreign body, volvulus or intussusception. The chronic obstructive signs are irritable colon, visible peristalsis, pain.

The diagnosis of cancer of the rectum and colon is made by digital rectal examination, sigmoidoscopy and by x-ray barium enema.

Colitis:—Colitis is frequently confused with irritable bowel, spastic colon, and various other conditions which affect the colon. The abuse which

the term colitis so commonly receives makes it apparent that knowledge of its true character is not sufficiently widely disseminated. The term colitis represents definite disease entities in which there occur well-defined pathological changes in the mucous membrane of the large bowel. Inflammatory changes may secondarily involve the entire gut wall. The inflammatory changes in the mucous membrane in colitis are of catarrhal, purulent, sangineous or ulcerative character. Their causes are outlined on the chart which follows:

Colitides

- Infections
  - Infectious Diseases
  - Syphilis
  - Amoeba
  - Intestinal Parasites
- Foods
  - Irritants
  - Fruit juice
  - Cellulose
  - Decomposition
  - Fermentation
- Deficiencies
  - Minerals
  - Vitamins
- Poisons
  - Metallic
    - Lead
    - Mercury
  - Organic
    - Ptomaine
- Cathartics
- Mechanical irritants
- Endogenous poisons
  - Burns, uremia, gout
- Endocrine

The most important clinical types of chronic colitis form the ulcerative group. The most common types of ulcerative colitis are (a) bacillary dysenteries (b) idiopathic chronic ulcerative colitis (c) amoebic infestation and (d) tuberculosis. Idiopathic chronic ulcerative colitis is a dreadful disease occurring in the prime of life; and is not particularly uncommon. It begins in the rectum in 95% of cases and is thus readily diagnosed by sigmoidoscopy. Sigmoidoscopy is a most important procedure in the diagnosis of colitis. Nevertheless, in certain cases barium enema x-ray studies are indispensable.

Fistula:—Fistula may be external or internal. External fistula connect some part of the colon with the surface of the abdomen. They result from such causes as a surgical operation, trauma, various ulcerative processes. Internal fistula usually connect colon to colon, or colon to ileum, stomach, bladder or vagina. Gastrocolic fistula most often develops from cancer of the greater curvature of the stomach. Vesicosigmoid fistula usually results from diverticulitis, chronic ulcerative colitis and carcinoma. The x-ray is very useful in the diagnosis. The treatment is essentially surgical.

Megacolon:—Megacolon is chronic dilatation of one segment, several segments or the whole colon. The sigmoid is the most frequent site of localized megacolon. The outstanding symptom is obstipation. The diagnosis is confirmed by x-ray and the treatment is essentially surgical.

Sarcoma:—Sarcoma is rare. It has a tendency to form much larger tumors involving larger areas of the bowel than does cancer. Its infiltration of the bowel wall destroys the nerve endings and gross dilatation of the lumen of the segment of the colon occurs. The annular constriction so characteristic of cancer is rarely produced by sarcoma.

Benign Tumors:—Benign tumors, such as fibroma, myoma, lipoma occur rather rarely, and may be confused with carcinoma. However, from a practical clinical standpoint any colonic tumor is to be considered cancerous until microscopic examination of the excised mass proves it to be otherwise.

Granulomatous Lesions:—Of the specific granulomatous lesions both syphilis and actinomycosis are rare. However, the possibility of their presence and especially of lues, is to be considered in the diagnosis of colonic lesions. Ulcerative tuberculosis of the rectum or colon will occur in the presence of advanced pulmonary tuberculosis. However, hyperplastic tuberculosis, or tuberculoma, occurs in the absence of advanced tuberculosis in other organs of the body. Tuberculoma is an exceedingly chronic condition, and it may become far advanced before giving rise to definite symptoms. Early symptoms may be those merely of mild dyspepsia, or the onset may be characterized by the severe pain of intestinal obstruction. In other cases the symptoms may simulate appendicitis or gall stone colic. The cardinal symptoms are abdominal pain, loss of weight and diarrhoea; gross hemorrhage is rare. A mild grade of secondary anemia is common and a tumor in the cecal region may be palpable. The ileocecal region is most often involved, and the rectum but seldom. The tumor

is to be differentiated from cancer. If the x-ray barium enema shows simultaneous involvement of the ascending colon, cecum and terminal ileum, then the presence of hyperplastic tuberculosis is probable. Ulcerative tuberculosis is treated medically, while hyperplastic tuberculosis is treated surgically.

Nonspecific infective granulomas are tumor masses composed of granulation tissue. They occur most frequently in the cecal region and often resemble a malignant growth in their appearance both grossly and in the x-ray film after a barium enema. The symptomatology may begin abruptly as an acute inflammatory process. This finding is of aid in differentiating nonspecific granuloma from cancer and hyperplastic tuberculosis. Occasionally the granuloma is readily palpable on physical examination; more often its demonstration can be made only by means of x-ray barium enema. Usually the differential diagnosis between granuloma and cancer can be made only at operation.

Parasitic Infestation:—As you know a number of parasites may infest the bowel; among which amoeba, tapeworm and round worm are familiar to all of you. Infestation with endamoeba histolytica is not a tropical disease, it is world-wide in its distribution. Amoebic infestation occurs probably more frequently than generally supposed because we are not in the habit of examining the stools for the presence of amoeba or amoebic cysts.

Amoebic dysentery is also a type of chronic ulcerative colitis, which is subject to remissions and relapses. The relapses are often characterized by sudden, almost explosive onset of diarrhoea. The diarrhoea consists of fluid stools containing mucous and blood and also shreds of mucous membrane. The abdominal wall is often rigid and tender. Because of the tendency of the disease to localize in the cecum and ascending colon, pain and tenderness in the right iliac fossa may resemble that due to acute appendicitis. Often the acute symptoms begin to subside within a few days. However, if the case is protracted the usual degree of weakness increases greatly and the patient becomes much emaciated and seriously toxic. Fever is variable but in the acute fulminating case may rise to as high as 103°-104° F. Bacillary dysentery may be a complication. When leucocytosis occurs in amoebic colitis it indicates either a mixed infection or the occurrence of a remote complication such as hepatic abscess, peritonitis, etc.

The diagnosis is made by finding the amoeba or its cysts, sometimes sigmoidoscopy is most helpful. Treatment will not be discussed other than to state that emetine hydrochloride remains the most useful drug.

Bacillary Dysentery

As you know many types of dysentery bacilli are recognized. Infection with any of these leads to general systemic symptoms together with severe inflammatory involvement of the mucous membrane of the large bowel; readily discerned by sigmoidoscopy. The diagnosis is confirmed by bacteriological cultural and agglutination methods. The treatment includes the administration of antibacillary serum.

Volvulus and Intussusception

Volvulus of the cecum may resemble appendicitis. Both volvulus and intussusception produce the symptomatology of intestinal obstruction.

Appendicitis

Appendicitis is obviously too large a subject to more than mention in this discussion.

Appendices Epiploicae

The appendices epiploicae are pouches of peritoneum filled with fat. They are subject to inflammations, the symptoms are those of localized peritonitis.

Secondary Disorders of Colon

The mechanisms producing functional disturbances of the large bowel undoubtedly involve numerous and complicated factors. Whatever these factors may be, their end results are largely abnormal changes in muscle tonicity and in sensitivity of reflexes. Such abnormal changes will occur in any clinical condition organic or nonorganic, which affects the muscle of the bowel or its nervous mechanisms. These conditions include all the intrinsic organic affections of the bowel which we have discussed. They include diseases extrinsic to the bowel, as nephritis, cardiac, pulmonary or cerebrospinal affections. They include states of malnutrition and states of chronic fatigue due to either physical or emotional strain. They include factors which locally adversely affect the bowel, such as catharsis or an excessively rough diet. Thus the functional affections of the large bowel are but symptomatological manifestations of underlying disturbances.

Constipation

The failure to recognize that functional bowel affections are but symptoms has led to a vast deal of confusion concerning their clinical significance. The character of this confusion will perhaps be elucidated during a short discussion of constipation. Constipation is the prolonged retention of feces. Among the effects attributed to constipation is a train of symptoms commonly included under the term autointoxication. The whole conception of autointoxication is a nebulous one. It is probably based on the common observation that during the act of defecation unpleasant odors may permeate the atmosphere. These remarks are made to emphasize that the symptoms ascribed to autointoxication are due to something other than constipation. They are frequently the result of the underlying condition causing the constipation.

Many patients' powers of observation are so defective that they erroneously considered themselves constipated. In other words, these patients' brains are less active than their rectums; and as a result they become "colon minded." Therefore, it is essential that the physician learn exactly what the patient means by the term constipation. However, establishing the presence of true constipation does not establish a diagnosis, but merely the presence of a symptom. The next step is to ascertain the underlying clinical condition of which it is a symptom; an outline of these conditions has been discussed.

The treatment of constipation consists primarily of the treatment of the causative clinical condition, and secondarily of the symptomatic treatment of the constipation itself. Thus the character of the causative underlying condition governs largely the character of the therapeutic measures necessary. Therefore consideration of the treatment of constipation is concerned with the field of medicine as a whole. Whatever the underlying cause may be, the treatment of constipation symptomatically can almost invariably be successfully accomplished by simple measures. It is rarely, if ever, necessary to use complicated and spectacular procedures.

Irritable Bowel

Among the functional affections of the large bowel is a condition in which the musculature becomes highly irritable. This condition masquerades under several titles among which mucous or membranous colitis are common. However, colitis is not present although frequently there is a great hypersecretion of mucous. The essential feature is muscular irritability. This condition gives rise to attacks of colicky abdominal pain. Depending on the character of the muscle spasm there will be constipation, or diarrhoea, or constipation alternating with diarrhoea. In making the diagnosis both intrinsic and extrinsic organic diseases must be eliminated. The treatment consists in general physical and mental hygienic measures, a properly balanced diet of bland character, avoidance of drastic cathartics and elimination of such measures as so-called colonic irrigations.

In the diagnosis of affections of the large bowel the importance of the use of the sigmoidoscope and the x-ray can not be over emphasized. However, their use does not obviate the necessity for a painstaking history and a searching physical examination as part of a proper general medical examination.

Old News

A CASE FOR DIAGNOSIS

The Biblical reference to the son of the Shunammite woman has been used by writers of medical literature. Osler and McCrae cited it in their chapter on Sunstroke. Robertson quoted it in a paper on Intracranial Aneurysm. We quote from the King James version; II Kings IV

18 And when the child was grown, it fell on a day, that he went out to his father to the reapers.

19 And he said unto his father, My head, my head. And he said to a lad, Carry him to his mother.

20 And when he had taken him, and brought him to his mother, he sat on her knees till noon, and *then* died.

32 And when Elisha was come into the house, behold, the child was dead, *and* laid upon his bed.

33 He went in therefore, and shut the door upon them twain, and prayed unto the LORD.

34 And he went up, and lay upon the child, and put his mouth upon his mouth, and his eyes upon his eyes, and his hands upon his hands: and he stretched himself upon the child; and the flesh of the child waxed warm.

35 Then he returned, and walked in the house to and fro; and went up, and stretched himself upon him: and the child sneezed seven times, and the child opened his eyes.

Osler and McCrae: Principles and Practice of Medicine, tenth edition. 1930, page 378.

Robertson: Medical Journal of Australia, 2, 381, 1936.

THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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OSTEOPATHY

Little by little the word is being passed around that osteopaths have the same training as doctors in medicine and have to pass the same state board examinations. Careful scrutinizing of facts, however, will show that these statements are not to be taken at face value.

In the first place osteopathy as it is practised today is not based on demonstrable scientific facts. Many times these so-called dislocations or subluxations when checked by X-rays show absolutely no abnormality. If, as the osteopathic cultists say, all diseases are produced by pressure on the nerves and blood vessels, as these vessels and nerves emerge from the spinal column, and this pressure is caused by a dislocation, at least this dislocation should be demonstrated or felt.

Osteopathy as practised by Still has gradually been broadened until osteopathy may specifically explore various fields of medicine. Thus today you can get an osteopath to treat any disease. State legislators and adherents of the cultists have given them a place in legalized medicine.

Let us for a moment analyze the basic osteopathic training. Riesman[1] points out that the Philadelphia College of Osteopathy, one of the best in the country, gives a four years' course and requires for admission a four years' high school course and one year of college, comparable to what the best medical colleges used to require up to a few years ago.

Etherington[2] visited four of the six approved schools of osteopathy and found that the instructors worked part time only and there was a deficiency of patients for case studies. The schools were run for profit and one of the two best was found to be probably as good as a second-rate medical school of fifteen years ago, rating as a grade C medical school at the present time. The hospital and clinical facilities were entirely inadequate; the requirements for admission and length of courses fell below the standards maintained by medical schools.

In New York graduates of only two schools are able to qualify and 45.5 per cent of these fail to pass the basic requirements.

Franklin H. Martin[3] pointed out that the American College of Surgeons does not give approval to hospitals which extend their privileges to osteopaths. Yet there are hospitals which allow osteopaths to send patients for X-rays and there are physicians who take cases referred to them by osteopaths, to hospitals. Some physicians consult with them. In a certain hospital in a large city, a patient had telegraphed his osteopath in New York to come on to untwist some creak in his neck. The physician in charge sent a telegram to instruct the conductor to tell the osteopath to take the next train back to New York.

Paul Luttinger[4] points out that in California the average osteopath's yearly income is $7,490 and in Philadelphia it is $5,847, far in excess of the yearly averages of regular physicians. He concludes that a large part of the 45 odd million dollars which American consumers pay to osteopaths is wasted on unnecessary and ineffective "manipulative adjustments."

He further states that osteopathy has not made any contributions to scientific medicine except criticism, and that it is fundamentally at variance with scientific medicine, "yet there is a danger in latter-day osteopathy that by its show of adopting the externals of regular medical practice, it tends to persuade the public to regard the osteopath as a healer with adequate medical training. . . . As long as osteopathy subscribes to the tenet of subluxations, it will always remain unscientific, in spite of the lip service its adherents give to scientific medicine. Granted that the courses in osteopathy have been prolonged and the standards raised and its field broadened to include a smattering of everything taught in regular medical schools, osteopathic theory still considers structural derangement as the most important underlying cause of disease."

1. Riesman: The Lancet, 19:515, March 1935.
2. Etherington: J. A. M. A., 104:1549, April 27, 1935.
3. Franklin H. Martin: The Lancet, 19:514, March 1935.
4. Paul Luttinger: Consumer's Research Bulletin, April 1936.

RHODE ISLAND HOSPITAL

Clinical-Pathologic Conference

Tuesday, April 13, 1937

CASE PRESENTED BY DR. CHARLES F. GORMLY

A sixty-one-year-old, white, Armenian male, entered the hospital on January 23, 1937, complaining of weakness, loss of weight, and pain in the left hip. As far as I know, he had had no doctor until this time. He came to us with two separate complaints.

The patient was in good health until about a year before admission when, with no apparent cause, he began to have occasional pains in the left hip. These pains gradually increased in frequency and intensity until November, 1936, since which time he was forced to remain in bed because of his lameness and weakness. The weakness has increased rapidly. The patient stated that he had lost a lot of weight but didn't know how much. For three or four months before entry, he had had the "dry heaves"—rattling, wheezing breathing — and an increasing cough, productive of thick, yellowish sputum with occasional flecks of blood. There was no pain in the chest, no diarrhœa, constipation, nor tarry stools, no urinary symptoms.

Twenty years ago he had gonorrhœa and a penile sore. The past history otherwise was non-contributory. The family history was likewise non-contributory.

Physical examination showed an emaciated though well developed white male, lying in bed. He was very listless. There was no cyanosis nor jaundice. The pupils were equal and regular, reacting to light and to accommodation. The ears and nose were negative. The mouth contained several dirty, carious stumps. The mucous membranes were clear, the throat negative. The thyroid was not felt, the trachea in the mid-line, no lymphadenopathy. The chest was asymmetrical, the right side smaller than the left, expansion on the right limited. Percussion was not hyper-resonant anteriorly but was dull on the right posteriorly, especially at the right base. The breath sounds were everywhere increased, with patchy areas of bronchial breathing and many fine and coarse moist rales and ronchi throughout. The voice sounds varied from normal to nasal in quality. The heart was somewhat enlarged to the left and downward, the rate slow, the rhythm regular, the sounds distinct but of poor quality. No murmurs were heard. The blood pressure was 180/90/. On the abdomen, just to the right of the xiphoid, was a mass two by two cm., slightly tender, seemingly attached to the skin. The patient said that this was of recent origin. The liver was hard, irregularly nodular, and enlarged downwards four or five finger breadths. The spleen was not felt. There was no abdominal pain nor tenderness. The muscles about the left hip and thigh were markedly wasted. There was tenderness over the left sacro-iliac joint and left hip joint with no pain on motion nor limitation of motion of the joint. The rectum was negative. The prostate was small, soft, not tender.

There was nothing remarkable about the blood work. There were 3,650,000 red blood cells, 10,600 white blood cells, the hemoglobin was 74%. The differential blood count showed 80% polymorphonuclear leucocytes, 16% small lymphocytes, 4% large mononuclear leucocytes. The blood urea nitrogen was 24 mg. per 100 cc., creatinine 1.7 mg., glucose 87. The urine showed a specific gravity of 1.018, with albumen, a consistent trace to + 1. The sediment was negative. The Wassermann and Hinton tests were negative.

The X-ray showed a normal heart shadow with slight widening of the supra cardiac region. A dense rounded shadow continuous with the mediastinum suggested a mass at the right hilus region. Throughout the upper three-quarters of the right lung field there was fine mottled increased density with a circular area of increased density overlying the anterior end of the second rib. The left lung was entirely clear. No abnormality appeared in either hip region but there was evidence of considerable bone destruction of the left side of the sacrum and to a slight extent in the adjacent ilium. The exact nature of this bone destruction was difficult to make out because of gas in the intestines. We discussed this case at length with the X-ray department. Dr. Batchelder felt that there was some malignant disease of the lung. Many of the signs were such as we would expect with a bronchiectasis with sufficient blocking off of a large bronchus.

The condition ran a progressively downhill course with low grade afternoon temperature rise up to the ninth hospital day, the pulse running about 100. The patient then became unconscious and incontinent. The temperature gradually rose to 104.5. On the fourteenth hospital day the patient expired. We thought that the patient had either a malignant or a tuberculous lung. His appearance was that of a chest case.

Interpretation of X-ray Films

Dr. Batchelder: "The lighter areas of increased density" is an unfortunate term. I should have said "ring shadow." Here is the shadow continuous with the mediastinum. You can see, throughout the lung, this very fine mottled density extending through the apex and the base. Then coming to the pelvic film. It shows a large area of destruction in the wing of the sacrum. It is a little questionable whether or not it goes into the wing of the ilium. We asked for further examination which was not done. Stereoscopic films would have enabled us to see the bone more clearly. I don't see any other definite area elsewhere in the pelvic girdle. We have several films of the lower vertebrae. Having heard Dr. Gormly's reading and discussion of the case I think that what I said when I first saw the films still holds. I don't think that by the X-ray we can make a diagnosis between tuberculosis and tumor. There is very little bone reaction about it. In a tuberculosis of a year's duration I should think there would be some chance for a little attempt at repair in some places. In favor of tumor there is this mass in the hilus region but on the other hand this ring-shaped lesion is very suggestive of a small cavity. The sputum could then be explained as a drainage from the infected area.

Dr. Gormly: I think there were one or two negative sputums. His Wassermann was negative despite the story of the sore. I do think that Dr. Batchelder's description of the films would clearly indicate that we did not make a diagnosis. The comparison of the two sides is rather bizarre.

Q.: What was the rate of respiration?

Dr. Gormly: Twenty-five.

Q.: It says here that he had "dry heaves"—I have been accustomed to associate that with a rumbling stomach; is that right?

Dr. Gormly: Yes.

Dr. DeWolf: I want to ask Dr. Batchelder if there is any atelectatic area there?

Dr. Batchelder: We don't interpret it so. If so there is a very peculiar shaped area of atelectasis. He has quite extensive involvement and very likely some pleural involvement.

Dr. DeWolf: The thing we are all talking about —this wheezing. If you read the books—they all give as the earliest symptoms, wheezing and cough. I saw an article by Jackson in which he said that wheezing over the open mouth is quite indicative of lung tumor. This case shows those early symptoms. Cough, wheezing and later pain in the chest, but he did not have the pain. It seems to me the best guess would be malignant disease of the chest with secondary metastatic involvement in the bones.

Q.: Did he have a big and nodular liver?

A.: Yes.

Q.: Did he have metastatic involvement there?

A.: We suspect that.

Dr. DeWolf: It is quite interesting to note that about 90% of primary carcinomas of the lung are bronchiogenic in origin and come from somewhere in the main bronchus or outside it. Everyone seems agreed that this was in the lung. It is quite interesting to note the lame hip. It seems to me it was primary in the lung and later bone involvement but it appears that the lame hip came first.

I will take this opportunity to tell you about a case I have had, a woman with a primary carcinoma. She had pictures taken, some within two days of her first symptoms. I sent her to Dr. Churchill in Boston and within two or three weeks the woman had collapse of the lung. He did a pneumonectomy and the biopsy at the operative table showed a small bronchiogenic cancer and one little spicule going up to the surface of the lung. This woman was 61 years of age and had been an invalid all her life. She lived through it, got well and just 11 months later had pneumonia in the right lung. Both right lobes were involved but she went through that very successfully. Now two and a half years have gone by and she can do almost everything without too much exertion. Two months ago she came in and said she felt very peculiar in the left side of the face and hands: that is about all that has occurred. There were no glands found at this operation and he got well up on the main bronchus. She weighs 2 lbs. more than last fall. Barring this thing she is pretty well.

Q. Will you say a word about the effect of smoking? In these cases of cancer of the lung, as I take it, most are in males and they are seen in people who use tobacco excessively. What is your own thought about that?

A. I know nothing whatever about it.

Dr. Corvese: I have had two cases of metastatic cancer of the femur, both in females and both heavy smokers. These two cases were primary cancer of the lung with secondary fracture of the femur.

Dr. Chafee: There was reviewed in the *A.M.A. Journal* an article which showed that cancer of the

lung is definitely on the increase since the war. There was a good deal of discussion as to whether cancer of the lung was not enhanced because of the tar used on the road. I had a tip on the type of cell in this lesion so I looked particularly and the only thing I could find was an article in a German magazine and as I cannot read German I am unable to report it.

Report of Postmortem Findings

Dr. Clarke: At the time of postmortem the man was quite emaciated. In the right axilla and in the right supraclavicular region there were some glands cut down upon which presented a gray, granular, friable material thought to be typical of carcinoma. The peritoneum itself was negative but up in the region of the pancreas was a mass of glands, not a single mass but numerous glands which measured 8 or 10 cm. across. Following down from that were large glands and there was extending into the left sciatic notch and surrounding the sciatic nerve on the left a gray, dense, unencapsulated tissue from which could be scraped a milky substance. Grossly it resembled that in the chest.

Along the trachea are these large lymph glands which are 3 or 4 cm. in diameter. The bulk of the mass is a gray, granular, friable tissue. Here is another large gland located exactly at the bifurcation. Radiating into the substance of the right lung, apparently following along the bronchi is a firm, white, grayish tissue. Here is one large discrete tumor nodule. The remainder of the lung showed a broncho pneumonia which we interpreted as being a fairly terminal affair.

I have here a section through the liver and it is filled with tumor masses. Here is the kidney and there is one little mass, and so there was tumor also in the kidneys.

Then there was this mass described in the pelvis which seemed to invade directly into the underlying bone.

At the time of postmortem all of these tumors were noted and there was much speculation as to which was primary. The bronchi were followed out carefully and there was no place where the mucosa seemed to be actually ulcerated or involved. Here was this large nodule in the lung but no bronchus could be found to communicate with that, nevertheless. It was decided the primary tumor was in the lung.

However, when we saw the microscopic sections it became evident that the gross opinion was wrong. This histology is specific for a type of tumor derived from nervous tissue. These rosettes are unmistakable. They are duplicated in the normal embryology of the adrenal medulla. The most common location of primary tumor of this type is the adrenal medulla. They are also frequently seen in the retina. More rarely cases have been reported in the central nervous system and in the retroperitoneal tissues.

The adrenals and the retinæ in this case were negative. The largest tumor mass was retroperitoneal in the pelvis. The first symptom was pain in the hip. We conclude therefore that this tumor originated from retroperitoneal sympathetic nervous tissue.

Diagnosis: Neurocytoma of retroperitoneal origin with metastases to lungs, liver, kidney and retroperitoneal, mediastinal and axillary lymph glands.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the

One Hundred and Twenty-sixth Annual Sessions

(Continued from Page 134)

Report of the Trustees of the Fiske Fund
One hundred and second year.

Trustees:

John E. Donley, M.D.
Walter C. Rocheleau, M.D.
James W. Leech, M.D. (Deceased)

Secretary to the Trustees:

Wilfred Pickles, M.D.

June 1, 1937 — First Meeting of the Year

The meeting was held at Dr. Pickles' office and was attended by Drs. Donley, Rocheleau, and Pickles. The response to the announcement of the competition for the year 1936-1937 was very disappointing to the Trustees, and after careful consideration it was decided that no essay submitted met the requirements as laid down by the Trustees and it was voted that no premium be awarded.

It was further voted that a premium of one hundred and fifty dollars be offered for an original essay to be submitted in the contest closing on May 1, 1938, on the subject "Surgery in the Treatment of Disorders of the Autonomic Nervous System". The regulations governing the dissertations were left as in the past few years, and original work and observations are desired.

The secretary was authorized to pay for the care of Dr. Fiske's grave, and to pay to the Catalogue Fund of the Medical Library the emolument awarded to the Trustees by the will of Dr. Fiske.

The usual Financial report was submitted by the Secretary and was accepted by the Trustees.

Respectfully submitted,

WILFRED PICKLES, M.D.,
Secretary to the Trustees.

Report of the Committee on Legislation

There was almost no medical legislation passed at the last session of our State Legislature.

Senate Bill 45, entitled "Crippled Children." This is a part of the Federal Social Security program passed in Washington, January, 1935. This act matches the sum of money allotted by the Federal Government to our State for the care of crippled children.

Senate Bill 125, entitled "Medicines and Poisons." This bill gives the Division of Narcotic Drugs and Pharmacies jurisdiction over the dispensing of barbital compounds or other hypnotics or somnifacient drugs. None of these drugs can be sold except on prescription or given by a physician directly to the patient.

Respectfully submitted,

HERBERT E. HARRIS, M.D., *Chairman.*

Report of the Committee on Maternal Mortality

The committee is still studying the material collected in its five years survey of the maternal mortality in Rhode Island. It expects at a later date to present to this Society its findings and conclusions.

Respectfully submitted,

EDWARD S. BRACKETT, M.D., *Chairman.*

The Association of Military Surgeons of the United States will hold a meeting at Los Angeles, California, on October 14, 15 and 16, 1937. An interesting program will be provided. Lieut. Col. E. C. Moore, 511 South Bonnie Brue, Los Angeles, is the Chairman.

Memorial Hospital

NEW ENGLAND ANESTHETISTS TRAVEL GROUP

The Horace Wells Travel Group of Anesthetists met at the Memorial Hospital on July 31. Present were Drs. Brian C. Sword, New Haven; Ralph M. Tovell, Hartford; I. S. Geetter, New Britain; Charles H. Shamlian, Springfield; George C. Moore, Boston; Russell F. Sheldon, Boston; Sidney C. Wiggin, Boston; Mary A. Leavitt, Holyoke; Albert H. Miller, Providence; John S. Hayward, Providence; Elihu Saklad, Providence; Meyer Saklad, Providence. At the morning sessions, the following demonstrations were given: —By Dr. Miller; Positive pressure nitrous oxide oxygen; Nitrous oxide oxygen ether gravity induction. By Dr. E. Saklad; Cyclopropane oxygen. By Dr. M. Saklad; Spinal anesthesia. The surgical operations were performed by Drs. Frederic V. Hussey, Eliot A. Shaw, and Henry B. Moor. Luncheon was served at the hospital at 1 P. M.

At the afternoon sessions, the following demonstrations were given:—By Dr. E. W. Benjamin; Demonstration of X-Ray films showing the effect of 100% oxygen on intestinal gas. By Dr. Miller; Posture of patients for surgical procedures, with special reference to thyroid and gall bladder surgery. By Dr. E. Saklad; Bacteriologic studies in closed circuit anesthesia apparatus. By Dr. M. Saklad; Demonstration of apparatus for helium oxygen and 100% oxygen therapy. Posture of patients for thoracic surgery with particular attention to a new posture. Consideration of a proposed record keeping system. At 7 P. M. a Rhode Island Clam Bake was served at the Squantum Club.

Dr. Natalie Kechijian has been appointed to the anesthesia service which now gives Dr. Meyer Saklad, chief of service, four staff assistants. This makes for efficiency in the anesthesia department.

A new supervisor has been appointed to act as a liaison officer between the members of the staff and the nursing force, both private and staff nursing, thus making for greater efficiency in the carrying out of recommendations, records, etc.

Dr. E. B. Gammell completed a year's internship at this hospital on July 31, 1937 and is at present practicing in Hope Valley, R. I.

Dr. Laurence A. Senseman has completed his year's interneship at this hospital and is at present with the Harding Sanatorium, Worthington, Ohio.

Rhode Island Hospital

SCHEDULE FOR SEPTEMBER, 1937

Mondays

10.00 A. M. September 13, 27.
I Surgical Grand Rounds
September 20.
II Surgical Grand Rounds

4.30 P. M. Thoracic Clinic

Tuesdays

9.00 A. M. Gastro-Intestinal Clinic

10.00 A. M. September 7, 21.
I Surgical Grand Rounds
September 14, 28.
II Surgical Grand Rounds

Wednesdays

10.00 A. M. Tumor Clinic

12.00 noon Skin Clinic

Thursdays

9.00 A. M. Orthopedic Grand Rounds

11.00 A. M. Thoracic Clinic

Fridays

11.00 A. M. Fracture Grand Rounds
September 3, 17.
Pediatric Grand Rounds

11.30 A. M. September 10, 24.
Heart Conference

7.30 P. M. September 3.
G. U. Staff Meeting

8.30 P. M. September 3.
Surgical Staff Meeting

Saturdays

9.00 A. M. Neurological Grand Rounds

11.00 A. M. Medical Conference

Dr. Francesco Ronchese sailed for Europe on Thursday, August 19th. He plans to visit France, Italy and Vienna, before he returns in October.

Dr. Ralph Jardine, who finished his interneship on the 1st of August, was married on July 31st to Miss Virginia Walsh in Watertown, Mass. Dr. Jardine plans to start his service at Wallum Lake Sanatorium in September.

Dr. and Mrs. Henry Atha, of Thomaston, Conn., visited the Rhode Island Hospital during this past month.

Dr. Wesley N. Wasgatt, a graduate of Columbia University Medical School, began his interneship on August 15th. Dr. Wasgatt's home is in Rockland, Maine.

Dr. John A. Rodger, a graduate of the University of Syracuse Medical School, began his interneship on July 15th. Dr. Rodger's home is in Moravia, N. Y.

Dr. Charles W. Higgins, Senior Consulting Surgeon of the Department of Gynecology, died on August 19. He passed away quietly as he slept.

Dr. and Mrs. Harry C. Messinger return on September 4 from a trip to London, Paris, and Austria.

Woonsocket Hospital

The regular meeting of the Woonsocket Hospital Staff was held on July 12, 1937, with Dr. T. Frank Kennedy presiding. Dr. Henri E. Gauthier read a paper on "Interpretation of the Schilling Hemogram in Appendicitis" with lantern slides demonstrating his lecture. Two new members were appointed to the medical staff, Drs. Richard Dowling and John Cicchetti.

The July clinical conference was held on the 26th. A case of colitis was presented by Dr. J. Edgar Tanguay and then followed a round-table discussion, Drs. F. J. King, Stephen Emidy, W. A. King, A. Fontaine and G. Dupre participating.

OBITUARY

WILLIAM A. BERNARD, M.D.

Dr. William A. Bernard of Woonsocket, R. I. died July 11, 1937 at the age of 62 years, following an illness of several months duration. He was born in Lowell, Mass., but had been a resident of Woonsocket for many years. He received his medical education at the University of Montreal and was graduated in 1899. He was established in Woonsocket in 1900. For years he was an active member of the Woonsocket District Medical Society and of the Woonsocket Hospital Staff. He served as President of the Woonsocket District Medical Society and had been a member of the Medical Board of the Woonsocket Hospital Staff. He was also a member of the Medical Board of l'Union St. Jean Baptiste d'Amerique. From 1923 to 1925, he served as City Health Officer.

HENRI E. GAUTHIER, M.D.

FIRST "APHORISM" OF HIPPOCRATES

Life is short, and the Art long, the occasion fleeting, experience fallacious, and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals co-operate.

RECENT BOOKS

Operative Surgery. By J. Shelton Horsley, M.D., LL.D., F.A.C.S., and Isaac A. Bigger, M.D. With Contributions by C. C. Coleman, M.D., F.A.C.S., John S. Horsley, Jr., M.D., Austin I. Dodson, M.D., F.A.C.S., and Donald M. Faulkner, M.D. Fourth Edition. Two volumes, pp. 1387. With many Illustrations. Cloth, $15. St. Louis, The C. V. Mosby Company, 1937.

For many years the first edition of Dr. J. Shelton Horsley's book "Operative Surgery," published in 1921, has been in constant use by students of surgery as have his later editions, the second edition being published in 1924 and the third edition in 1928. Each edition has been valued for its clearness and simplicity of exposition and the admirably graphic representation of many complex features of the field of operative surgery.

In the first three editions of "Operative Surgery" by Dr. J. Shelton Horsley, the treatise on each occasion was written and edited by Dr. Horsley himself. In the present fourth edition Dr. Horsley has rewritten large parts of the book without, however, sacrificing the many good qualities of his previous editions. He is ably assisted by Dr. I. A. Bigger, Professor of Surgery at the Medical College of Virginia, who acted as co-author and they together give an excellent cross-section picture of operative surgery brought up to date.

To cover the large field of operative surgery as they do in two volumes, the following men collaborated with the authors: Dr. C. C. Coleman, Professor of Neurological Surgery at the Medical College of Virginia wrote on the Surgery of the Central Nervous System and the Cranial Nerves; Dr. A. I. Dodson, Professor of Urology at the Medical College of Virginia, on Urology; Dr. John S. Horsley, Jr., Assistant Professor of Surgery at the Medical College of Virginia, on Plastic Surgery; Dr. Donald M. Faulkner, Associate Orthopedist to the Medical College of Virginia, on Orthopedic Surgery and Dr. Guy W. Horsley gave aid in the preparation of the chapter on Proctology.

This fourth edition follows the same general lines as the other editions and as Dr. Horsley states in the preface of the book, "It does not attempt to be an encyclopedic work." He further states that "Many new operative procedures are described which have not heretofore been published in a book but none has been recommended which does not seem sound."

There are many new chapters such as the chapter on the Surgery of Acute Abdominal Conditions and much of the work in the special fields has not heretofore appeared in any book. Dr. Coleman, Dr. Dodson, Dr. John S. Horsley, Jr. and Dr. Faulkner have all included a number of new procedures in their various specialties, some of which are original with them. The illustrations are numerous and well done.

In dealing with the chapters on General Considerations; Surgical Drainage; Technic, Sutures and Instruments, Dr. Horsley has admirably set forth principles of surgery which every surgeon should know.

"Operative Surgery" is a book which every surgeon should be familiar with, for it is an excellent treatise and can serve as a good reference book and a fine survey of present methods of surgical technic.

Adolph W. Eckstein, M.D.

Surgical Anatomy. By Grant Massie, M.B., M.S. (London), F.R.C.S. (Eng.). Third edition, enlarged and revised, pp. 478, with 153 illustrations, many in colors. Cloth, $6.50 net. Lea & Febiger, Washington Square, Philadelphia, 1937.

This hand book of surgical anatomy contains 478 pages of text and 153 illustrations, many of which are colored. The author divides the work into six chapters, the largest of which as would be expected, is devoted to the abdomen and pelvis. In addition to general surgery this book also deals with the surgical anatomy of the eye, ear, nose, throat and autonomic nervous system.

All of the essential points of anatomy relative to the more common operations are covered in a very readable manner, without going into prolonged detailed descriptions. This makes this book a valuable addition to the surgeon's library. What has been said of the text is also true of the illustrations. They are well chosen and easily understandable. As an example of brevity without the sacrifice of important facts, the section dealing with the surgical anatomy of the hand, with special reference to infections, may be cited. Although all sections of the work are admirably done, that which deals with the surgical anatomy of the abdomen is to be especially commended.

J. Murray Beardsley, M.D.

Synopsis of Gynecology. By Harry S. Crossen, M.D., F.A.C.S., and Robert J. Crossen, M.D. Second Edition, 247 pages, illustrated. Cloth, $3.50. The C. V. Mosby Company, St. Louis, 1937.

This is a concise, pocket sized outline of gynecology based on the senior author's textbook "Diseases of Women." It is intended primarily for the medical student and for the general practitioner who may wish a guide to the leading points in gynecologic examination, diagnosis and treatment without the mass of detail found in the larger textbooks.

The book contains an excellent section on the anatomy and physiology of the pelvic organs, entirely revised since the first edition five years ago because of the rapid advances made in the study of the female hormones, and this is probably its best feature. There are also sections on the general methods of gynecologic examination, gynecologic diagnosis and gynecologic treatment, followed by more specific chapters on the pathology, etiology, symptoms and treatment of the diseases of each of the pelvic organs.

As a clear, brief, well illustrated summary of the common pelvic disturbances, this book is excellent, but of course, it cannot take the place of one of the standard textbooks. The chief criticism that may be leveled at it is the rather small size of the print.

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Flinn, "Laryngoscope" Feb. 1935—Page 152

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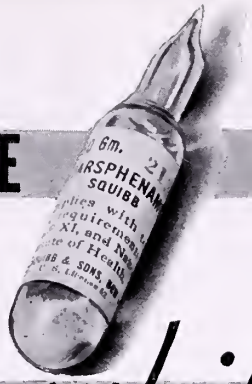
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[1] Cole, Harold N., *et al.; J. A. M. A.* 108:22, 1937.

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In This Number

Trigeminal Neuralgia and Meniere's Syndrome. By Dr. Gilbert Horrax

Primary Pneumococcus Meningitis. By Dr. Charles A. McDonald and Milton Korb

On Growing Old Gracefully. By Dr. Charles F. Gormly

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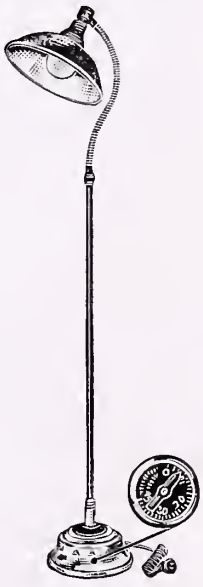
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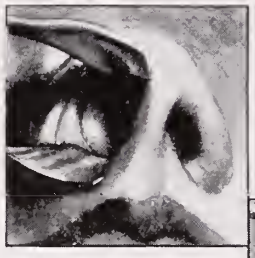


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CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSES

● In June, 1935, this space was devoted to a discussion of some of the general aspects of latent avitaminoses. It appears pertinent to report some of the more recent ideas in regard to this important field.

Considering the subject of avitaminoses in its entirety, the modern medical attitude is aptly expressed by the following statement: " . . . the mild or latent forms of the vitamin deficiencies are more important in practice at present than the fully developed cases. The latter are uncommon, are easily recognized and are usually promptly and adequately treated. On the other hand there is reason to believe that minimal or mild forms of these diseases are much more frequent, often escape recognition and, because of their insidious effect on large numbers of people, constitute a more serious problem than the occasional advanced cases." (1)

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(1) 1937. J. Am. Med. Assn. 108, 15.
(2) 1936. J. Nutr. 12, 405.

(2) 1936. J. Am. Diet. Assn. 12, 231.
1936. J. Nutri. 11, 383.
1936. Ind. Eng. Chem. 28, 1009.

(2) 1935. J. Home Econ. 27, 658.
1935. U. S. Pub. Health Rpts. 50, 1333.
1935. Am. J. Pub. Health 25, 1340.

This is the twenty-ninth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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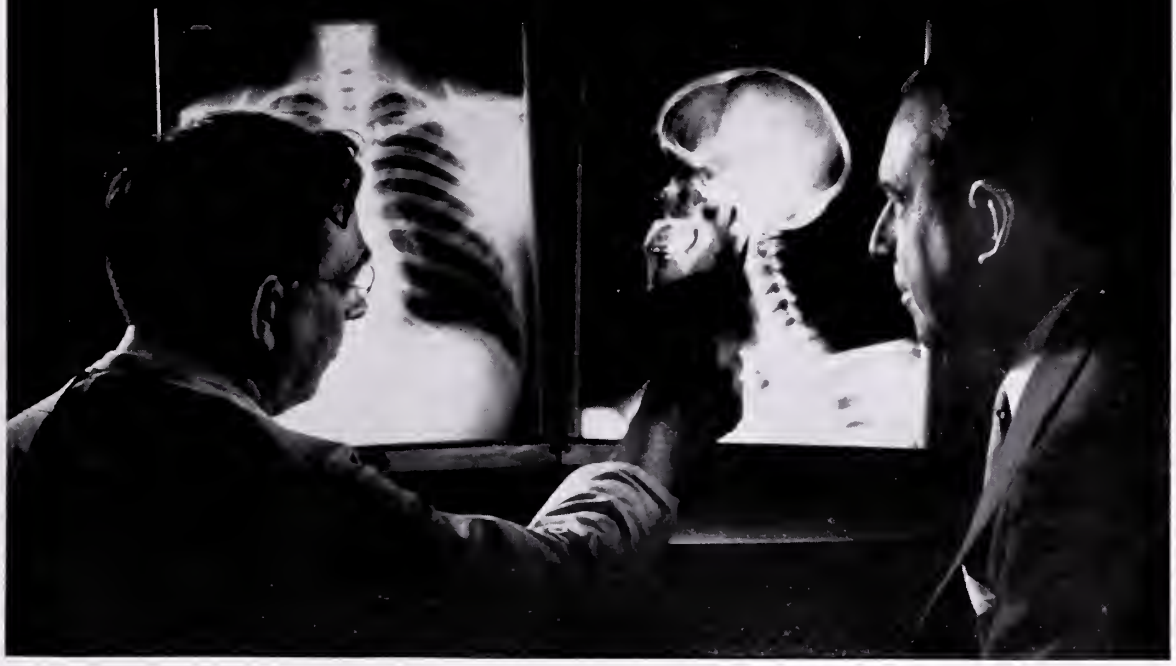
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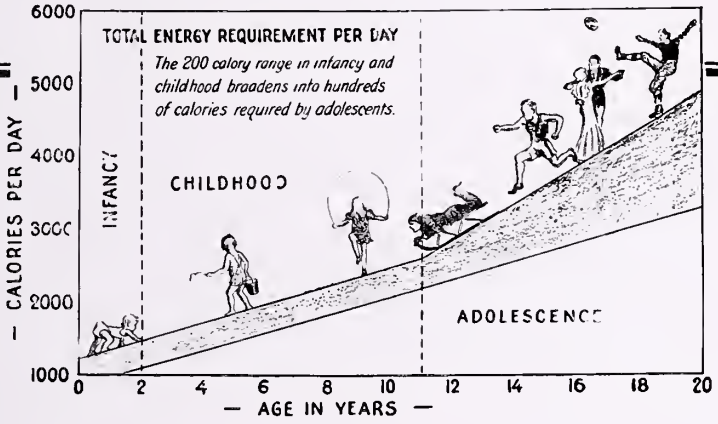
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THE RHODE ISLAND MEDICAL JOURNAL
Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 10 | Whole No. 337 | OCTOBER, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

A DISCUSSION OF CERTAIN ASPECTS OF THE DIAGNOSIS AND TREATMENT OF TRIGEMINAL NEURALGIA AND MENIERE'S SYNDROME

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Although trigeminal neuralgia and Meniere's disease are well recognized clinical conditions, there are certain aspects concerning the diagnosis but more especially recent developments in the treatment of both these disorders which are perhaps not so fully understood as they should be. It is, therefore, to these points that I shall call your attention this afternoon.

Trigeminal Neuralgia. There are many kinds of pain which occur in the face within the distribution of the fifth cranial nerve, but the term trigeminal or trifacial neuralgia (tic douloureux) is confined to that specific, paroxysmal, lancinating and at times prostrating pain with which most of you are familiar. Its cause is as yet unknown, but its usual course is one of recurrent attacks which may last from a few days to several months. During these attacks the patient suffers from frequent paroxysms daily, the number varying from perhaps two or three throughout the twenty-four hours up to the point where they may come every few minutes so that practically no respite is obtained. The individual pains may last anywhere from a few seconds up to a minute or two. When such a pain ceases, which it does abruptly, there is entire freedom from pain sensation until the onset of the next paroxysm. If one has ever seen a patient experiencing such an episode it cannot be mistaken for any other condition, but if one has to rely merely on the description of an attack there are at times some uncertainties of diagnosis. True trigeminal neuralgia, however, must be clearly differentiated from other types of facial pain since the treatment for it is specific. Only in rare instances will this treatment be of help in other painful disorders of the face.

If one can put any credence in the statements of patients, there appears to be considerable doubt in the medical profession as to just what may and what may not be accomplished for patients who have chronic trigeminal neuralgia. One hears a variety of conflicting opinions which these patients say they have been given. Some say they have heard that the so-called "radical" operation is the one and only method by which they may obtain relief. Others have apparently been told that this operation always leaves the face paralyzed and disfigured, so that they should never submit to anything but an alcohol injection. Again, the horrors of an alcohol injection have been painted so black, and the danger of operation assumed to be so great that the patient has been allowed to go for months, sometimes years, before he or she can be convinced that relief may be obtained almost always safely and surely, so far as the operation is concerned, or with relatively slight pain if an injection is indicated.

It is quite obvious that there must be some underlying reasons for all these impressions, erroneous as they are, and it is probable that they are not far to seek. So far as facial palsy following operation is concerned it may be said that not too many years ago a transient facial palsy was not uncommon following division of the trigeminal root, but we have now learned that traction on the greater superficial petrosal nerve was the probable cause for this, and means can be taken to avoid such traction. As a result, only two temporary facial weaknesses have occurred in the last 200 operations of our series. Another reason for withholding operation was the trouble which arose because of corneal anesthesia and subsequent possible complications from persistent keratitis. This difficulty has been overcome in the vast majority of patients by dividing only the lower two-thirds of the root, thus

From the Neurosurgical Service of the Lahey Clinic, Boston, Mass.

Read at the annual meeting of the Rhode Island Medical Society, Providence, June 3, 1937.

preserving corneal sensation and eliminating any chance of ulceration. It is necessary to divide the whole root in only those rare cases in which the neuralgia has begun in the ophthalmic division, or possibly in a few more where all three divisions are essentially involved; i. e., where the first division pain is not in the nature of an "overflow" upward from what is really second division neuralgia. Finally as in all surgery, it seems to be true that the occasional patient who has obtained a poor result is the one whose condition everyone appears to know about, rather than the "ninety and nine" who have only the greatest thanks for their relief.

In the case of alcohol injections I feel that erroneous impressions must have arisen from a variety of reasons. Some patients have been led to believe that an alcohol injection produces permanent relief from pain. This may have been due to the fact that the person giving the injection did not make it clear that relief from such a procedure is almost inevitably temporary, although I have a number of instances in my series in which three to seven years freedom from pain has been secured. However, we find from our experience with 968 alcohol injections that the general average is from twelve to fifteen months. Again, some surgeons perform alcohol injections under a general anesthetic, and while this is of course painless, nevertheless the percentage of correct injections must be far less than when either novocain or no anesthesia is used. If therefore, the patient has to have several trials before a satisfactory injection is obtained, he doubtless gains the impression that this operation leaves much to be desired. Furthermore, anesthetization requires hospitalization and thus added expense, whereas with novocain or without anesthesia our injections are done almost invariably in the office and the patient may go home immediately. The matter of the pain endured during an injection without anesthesia must of course be given due consideration. In my opinion it has been very greatly exaggerated. If one has thoroughly familiarized himself in locating the divisions of the nerve, and uses a small calibre needle, there is usually only a momentary sharp pain when the nerve is actually entered. The alcohol and novocain mixture is then immediately injected, and the total experience is no worse than one of the patient's usual paroxysms. That this on the whole represents the usual picture, I have gathered from the statements of many hundred individuals. Here again there are exceptions. To some people the pain of an injection is such an ordeal that it should not be attempted, while I have seen others so stolid that it was almost impossible to tell when the needle had penetrated the nerve itself, so slight was their reaction to such a stimulus.

So much for the general facts relating to alcohol injections. The next question is, when should they be used in preference to the operation of root section which gives permanent relief. Here again there may be conflicting opinions, but after many years experience with both procedures I have arrived at the following conclusions:

1. When a patient first comes for treatment for trigeminal neuralgia of the second or third divisions, an alcohol injection is the procedure of choice first, because he or she can be given immediate relief in a relatively simple way from a recurring, agonizing pain. Second, and most important, an alcohol injection demonstrates to the patient for a temporary period the minor discomfort of numbness which they must have permanently after division of the nerve root. This may seem a small point, but actually there are a considerable number of patients who do not, or would not understand what this peculiar feeling is like, and if operated upon immediately never seem quite satisfied about this paresthesia which they must exchange for their pain, even though it has been explained to them in detail beforehand.

2. Alcohol injections are indicated in a good many elderly people whose life expectancy is not great. I have in mind certain rather feeble individuals in the eighties or even older. In my series there have been three patients who were ninety or over, all women. I do not mean to imply that age, per se, is a contraindication to operation, since many of our patients have been operated upon in the late seventies or eighties.

3. A third indication for alcohol injection is found in patients who have such extremely serious systemic conditions as to make the taking of an anesthetic inadvisable. This happens only rarely and only twice have I advised against operation for this cause. We have had a large number of patients with moderately severe heart lesions, high blood pressure and the like who have gone through the operation with no trouble whatever.

4. Finally it should be said that quite a number of patients who have had one alcohol injection prefer to go on with this method of treatment year after year until the procedure becomes difficult or

impossible because of the scar tissue which forms around the nerve after each injection. They are always told, however, that eventually they will probably have to submit to the operation, and are urged not to delay this too many years.

I believe that what I have just said covers the main points regarding injections. One further statement should be made, and that relates to patients having a purely supraorbital neuralgia. Here, injections are not very satisfactory owing to the fact that there are many small branches involved and these cannot as a rule be injected directly. For these patients I often advise a simple supra-orbital neurectomy. This involves only a few days in the hospital and many times will give relief for two to five years. They are thus spared for a considerable time from an inevitable corneal anesthesia if total root section is performed.

In regard to the so-called "radical" operation for trigeminal neuralgia,—namely partial or complete section of the sensory root behind the Gasserian ganglion, it may be said truthfully that when done by an experienced neurosurgeon the mortality should be less than one-half of one percent. It is difficult to understand why so many physicians still have the impression that this is a most hazardous procedure, because in point of fact it is doubtless less dangerous than the ordinary abdominal operation. This apprehension apparently dates back to the original Gasserian operations 25 or 30 years ago. In those days neurosurgery was in its infancy and the operation in question was fraught with considerable danger, but with the enormous experience and also certain technical simplifications which have come during the intervening years this apprehension should long since have vanished. Many articles from the leading neurosurgical clinics both in this country and abroad have reiterated the statements just made but for some reasons the old ideas still cling. In our own series, to January 1, 1937, there have now been 356 radical operations for sensory root section by the temporal route without a single death. Two patients, for specific reasons, were operated upon by the suboccipital approach and one of these died some 8-10 days after operation from a pulmonary embolus. I mention this merely for the sake of completeness, as the type of operation chosen doubtless had nothing to do with the single fatality. My own feeling, however, is that the suboccipital approach, which is intradural, must always be considered definitely more dangerous than the almost universally used temporal route.

Whichever route is chosen, a partial division of the root is now the procedure of choice in the vast majority of patients whose neuralgia has not started in the ophthalmic division and has not involved this area above the eye except by "overflow." The patient thus has a minimal area of anesthesia involving the lower portion of the face, leaving the cornea with normal sensation and thus obviating any possible eye complications. That the results of this operation are most satisfactory is shown by the appreciation of the patients who have thus been relieved of their trigeminal neuralgia. With rare exceptions they are the most grateful patients with whom neurosurgeons have to deal.

Meniere's Syndrome. This condition, as suggested by Dandy[1] is probably a "tic" of the eighth cranial nerve just as trigeminal neuralgia is of the fifth. Its most incapacitating symptom is the sudden and severe vertigo with which the afflicted person is seized. In addition to this there is usually marked tinnitus and varying degrees of deafness in one ear. True Meniere's syndrome must be distinguished from labyrinthitis, cerebello-pontile angle tumors and occasionally from a chronic cisternal arachnoiditis or post-traumatic discomforts producing similar symptoms. These differentiations are made largely on the basis of a careful history of the attacks, and the absence of findings which would be compatible with the other conditions, namely, outspoken cerebellar signs, choked disks, evidence of labyrinthine or middle ear infection, or obvious recent and severe cranial trauma.

Like trigeminal neuralgia the attacks of Meniere's vertigo come on suddenly and are often sufficiently severe to make even standing or walking impossible. The patient may have several such attacks in a day or they may come at intervals of a few days or longer. This may continue for a few weeks and the seizures then cease for many months, only to return unexpectedly.

We are indebted to Furstenberg[2] and Dandy[1] for the conservative and radical treatment of this condition. Furstenberg has advocated a salt free diet together with rather large amounts of ammonium chloride,—from 5 to 7½ grains three times daily, taking this for three days, then stopping for two, and continuing in this way for several weeks. Both he and others have had extremely favorable results by this dietary method. In many patients the attacks have ceased abruptly and have not recurred for long periods, in some instances a matter of years.

On the other hand, some patients are unable to follow out such a stringent diet, or the diet and ammonium chloride has no effect upon their attacks. In these patients either partial or complete section of the eighth cranial nerve is indicated. If the patient is already deaf on the side affected the whole nerve may be severed, but if hearing is present to an appreciable degree the vestibular portion of the nerve root is sectioned.

The operation is a relatively simple one. A small bony opening is made over the right or left suboccipital region according to the side affected. The dura is opened and the posterior cistern incised in order to liberate spinal fluid and thus gain room for retraction of the cerebellar hemisphere. By this retraction the eighth nerve, covered by arachnoid, is exposed in the cerebello-pontile angle. The arachnoid is opened and as much of the nerve sectioned as seems advisable. Care must be taken not to injure the facial nerve which lies just below the eighth.

Thirty-two patients with fairly typical Meniere's syndrome have been seen and treated. Twenty-four of these have on the whole responded well to the Furstenberg diet for the periods they have so far been followed,—one or two months up to two years. A few could not be followed or were not helped. The majority have had definite relief from their dizzy spells. Eight patients have been operated upon by eighth nerve section with no mortality. All but one of these have been completely cured of their severe vertigenous attacks, and it may be said here that in all reports this is the incapacitating symptom and the only one which is essentially benefited. The degree of deafness remains the same, and tinnitus as a rule is uninfluenced. The patients, however, are most grateful for the relief from vertigo. One patient has had little or no relief. In this instance the diagnosis may have been wrong or the condition of too long standing to be affected favorably. One other patient who had what appeared to be Meniere's syndrome has remained well for five years after a suboccipital exploration with division of adhesions around the eighth nerve and liberation of fluid.

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PRIMARY PNEUMOCOCCUS MENINGITIS

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Milton Korb
Research Associate

Primary pneumococcus meningitis is pneumococcus meningitis without any recognized pneumococcus infection of the ear, of the chest, or of any other part of the body. About the disease much has been written by Kolmer and others. We will not review the literature. In this paper we are especially interested in the rapid course of the disease from onset to death. We are reporting four cases to demonstrate this point. The average duration of the disease was less than 3 days, the shortest duration was 2 days, the longest was 3 days.

Patient 1: K. O. M., age 38, male. On Monday, October 27, 1929, this patient was normal and at business. On Tuesday he had pain in the right ear. Dr. Phillips sent him to Dr. Sargent, who found a furuncle of the external auditory canal and prescribed carbolized glycerin. The drum membrane was not inflamed. On Wednesday he had some headache and was feverish and restless. At times during the day he was delirious, at other times he would take food and fluids and answer questions relevantly. Thursday he was more restless and delirious and was seen in consultation with Dr. Phillips and Dr. Burgess. The patient had blurred optic disks, and both eyes tended to roll outward. There was a mild neck sign, slight double Kernig, and dorsiflexion of all the toes on plantar stimulation. The slight degree of neck sign, of Kernig sign, and of papilledema was in marked contrast with the patient's general condition. The motor restlessness was striking. He rolled from side to side, grunting a bit as if distressed and seeking a comfortable position. One of us remarked that he acted as if he was "trying to get something off his brain." When stimulated to hold his head still for the eye examination his restlessness ceased, but for a few minutes only. To some questions he made appropriate replies. There were periods of apnea scattered at irregular intervals among rapid respirations of varying depth (Biot's Breathing). The pulse varied between 84 and 90, the blood pressure was 180/90, the eyeballs were soft, and there was no odor of

acetone. He was transferred to the hospital shortly after noon. There was sugar but no diacetic acid in the urine. The blood had 26,000 leucocytes with 90% polymorphonuclears and normal chemistry. He became cyanotic and died at 3:40 that afternoon. Post-mortem lumbar puncture showed cloudy fluid under high pressure with intracellular, gram-positive, lanceolate diplococci. The diagnosis was primary pneumococcus meningitis of 3 days duration.

Patient 2: S. W., age 46, male. This patient was seen by Dr. Winkler June 2, 1927, complaining of severe headache and left earache. He was seen again by Dr. Winkler at his office the next day. He complained of greater earache and headache. The drum membrane was normal looking except for slight redness of Schrapnell's membrane along the handle of the malleus. His earache was all out of proportion to the amount of visible aural pathology. He displayed violent motor activity; he was crying, pounding his head, waving his arms, and kicking about. Dr. Gilbert saw the patient and agreed with Dr. Winkler that there was no evidence of acute otitis media. On Sunday, the 3rd day of illness, he complained of stiffness of the back of the neck and drowsiness. He became feverish, and the drum was generally injected. At 1 P. M. Dr. Shaw observed good pulse, breathing, and reflexes. At 5 P. M. there was a consultation, at which Dr. Winkler, Dr. Shaw, Dr. McDonald, and Dr. Burgess were present. Since noon the clinical picture had changed much. The patient had respiratory decompensation of modified Cheyne-Stokes type. The right pupil was larger than the left. The neck was a bit stiff, and the optic disks were swollen. The left knee-jerk was more active than the right, and in acts of defense the right arm and leg were more skillful than the left. The pulse was 70, and the blood pressure 130/90. Death came 12 hours later on the 3rd day of illness. The diagnosis was primary pneumococcus meningitis of 60 hours duration.

Patient 3: J. R., age 21, male. This patient was admitted to the service of Dr. Gallagher of the Rhode Island Hospital February 24, 1931, complaining of headache, nausea, and vomiting of 4 to 6 hours duration. He had had a head cold and sore throat for a week. He collapsed while working and was brought to the hospital in an ambulance. Five hours after admission he complained of failing vision. Pupils were normal, and there was synchronous winking at objects thrust towards the eyes. He answered questions evasively and made irrelevant remarks. The pulse was 96, temperature 99.2, and respirations 18. He was restless, resisted examination, and would not cooperate in giving a history. Like the patient in case 2 he showed the violent motor displays seen in hysterical attacks. The blood pressure was 126/84. There was fine, bilateral nystagmus. The ears, throat, chest, and heart were normal. There was stiff neck, positive Kernig, and positive Brudzinski signs. There was no skin rash. He became very restless and noisy, and 4 drams of paraldehyde were given. At 7 P. M. the temperature was 104.2. He was resistive, thrashing about in bed and talking incoherently. The pupils were dilated, and the eyes had a peculiar stare. Lumbar puncture yielded cloudy fluid at a pressure of 500mm water. A smear showed many polymorphonuclears but no organisms. 30cc of antimeningococcus serum was injected intraspinally. A second lumbar puncture 18 hours later showed many pneumococci. There was some choking of the disks and bilateral weakness of the internal rectus muscles. 40,000 units of Felton's antipneumococcus serum was given in divided doses, after which he appeared better and was conscious. On the 2nd day of illness he suddenly became pulseless and died.

Patient 4: A. O., age 15, male. This patient was admitted to the Rhode Island State Infirmary January 2, 1937. He had had headache and "grippe" for 2 days. His condition became worse on the morning of admission. The pulse was 85, temperature 100, and respirations 30. He was stuporous and unresponsive, but would defend himself. He lay on his right side with knees drawn up and neck flexed. There was a mild neck sign and Kernig. There was no cervical adenitis, no abnormalities of the ears, chest, or abdomen. No knee-jerks, ankle-jerks, or plantar reflexes could be elicited. There was considerable improvement after removal of 15cc of cloudy spinal fluid under high pressure. It contained 6,360 leucocytes, mostly polymorphonuclears, with intracellular, gram-positive, lanceolate diplococci. There was no sugar in the fluid. On culture the organisms proved to be Group IV pneumococci. The blood contained 41,000 leucocytes, 87% polymorphonuclears. At 3 P. M. the pulse was 108, temperature 103, respirations 28. After withdrawal of 30cc of thick, viscous spinal fluid he was roused from stupor. At 7 P. M. the pulse was 138, temperature 103.2, respirations 48. At 11 P. M. the pulse was 160, temperature 104,

and respirations 100. He died at 1:45 A. M., January 3, 1937, with respiratory failure. The diagnosis was primary pneumococcus meningitis of 3 days duration.

Comment: We are reporting 4 cases of primary pneumococcus meningitis. In every case lumbar puncture showed intracellular pneumococci in the spinal fluid. In no case did routine examination reveal evidence of a primary pneumococcus infection in the ear, the chest, or any part of the body, to which the meningitis might be secondary. The onset was insidious. Nerve signs developed rapidly. Violent motor display was quite characteristic. Death came not later than the third day with respiratory failure. Case 1 lasted 3 days, Case 2 lasted 2½ days, Case 3 lasted 2 days, and Case 4 lasted 3 days. The average duration of the course of the disease was less than 3 days, the shortest 2 days, the longest 3 days.

DE SENECTUTE AMABILI

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Anyone who stops to consider the subject chosen for this talk will admit that, though it was not the easiest one that might have been selected, yet this subject of growing old gracefully is not only a pertinent topic but also a pious hope. Every life has a pattern, every human being represents an entity, a life to be lived completely through infancy, childhood, adolescence, middle age and into a graceful old age; yet how often destiny decrees otherwise. If we escape the very danger of being born, we are continuously confronted throughout our years with the interruption of this pattern by some acute illness or serious accident. As Dublin puts it, "This light will most surely burn out if nothing intervenes to snuff it out." There is a definite "span of life," indefinite as to its actual length, but probably something like a hundred years. How few ever live it out.

As we give some thought to the question of longevity, we soon realize that we can not demand a graceful old age but must achieve it. We in America may well be proud of our accomplishment in this direction and with Dublin we must admit that the credit goes to modern organization of the Public Health Service. Even now in our generation we cannot but be astonished by the fruits of the years of medical and sanitary struggle. In 1850, the expectation of life at birth in Massachusetts for white males was thirty-eight years and for females, forty and a half years. In the period, 1929-1931, it was fifty-nine years for white males and sixty-three years for white females. It is interesting to consider how this has come about. In these eighty years man has in no wise changed as a physiological entity; in fact, he has not changed appreciably in all recorded medical history. Obviously, it is due to man's better control of his environment.

The great improvement becomes evident statistically in the middle of the nineteenth century and must be basically attributed to the higher standards of living and the desire to live in a modern system of sanitation and public health. Modern medical science admits of no inertia; however, many other factors enter into this march of progress: the invention of the microscope by Jannsen as far back as 1590, the application of which did not bear fruit until the work of Louis Pasteur and Robert Koch in 1796; the work of Lister, the father of antiseptic surgery; the advances in the control of insect-bourne diseases by Reid, Ross and Gorgas; in the more recent conquests of glandular and nutritional deficiencies; the use of the X rays and radium and hundreds of less spectacular instances. So we return to this pattern or plan of life to find that we must somehow get through these preliminary stages of infancy, childhood, adolescence and middle age if we hope to reach a true old age.

At the very onset, we meet with so many threats to life, premature births, congenital malformations, congenital syphilis, that it is no wonder that the death rate is still very high. During that first year other threats arise such as diarrhœas and intestinal diseases. But it is here that we find one of the greatest triumphs of medicine. Perhaps in no place in the civilized world have you a better chance of escaping these hazards than in our own city. At our Lying-In Hospital, with its elaborate organization for prenatal care, its staff of extremely expert obstetricians and consulting specialists, with its follow up of post-partum care, the dangers and damages are at the almost irreducible minimum. This is not to be

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Notes on the popular medical lecture delivered at the Medical Library, Sunday, March 21, 1937.

construed as a plug for a local institution but is a country wide, if not world wide, admission of superiority.

When we come to the period of childhood, medicine holds its head high. On measles, whooping cough, diphtheria and scarlet fever a successful fight is being waged. Diphtheria is almost a rare disease. Unfortunately the threat of accidents is not such a pleasant story. Children's lives are sacrificed to all manner of accidents; the big six being burns, automobile accidents, mechanical suffocations, drownings, falls and poisoning.

Adolescence and early maturity bring new problems. The accident hazard remains. In fact, as long as the flame burns, this danger never leaves us. The type of risk and reason changes as we grow older but the fact remains; it is ever present in our sports, adventures and occupations. Then we come to tuberculosis, particularly a disease of this period. Within the memory of many of you this disease was the single greatest threat to human life in this region. If we persevere in our present expectations, it should go the way of diphtheria and malaria. Where is the typhoid fever of my interne days? Again the credit goes to public health, sanitation and education. One of the most pressing problems of this age group is maternal mortality. To reduce the danger of child-birth is one of the great challenges to the profession. It begins to show some decline but accidents of pregnancy and labor are still serious impediments to reaching that graceful old age.

In middle life and late maturity we are confronted with a different type of disease. We have the acute respiratory diseases like pneumonia and influenza, taking a terrific toll in this group, but year by year we are making progress in the treatment of these infections. It is to the so-called degenerative diseases that we must bow. We do not hope for such striking success in this battle, but the war will go on. Think what has been accomplished in diabetes since the discovery of insulin in 1921. Now, with the newer protamine zinc insulin, there can be an increase in the longevity of the diabetic, ranging from 90% in the young to 40% in the middle age group. The situation with heart disease is disturbing. Deaths from valvular damage and failure secondary to such infections as rheumatic fever are frequent at the early and middle ages. Deaths from chronic myocardial disease are more common in the later years of life and are frightfully on the increase.

Abnormal blood pressures are very common. The high pressures are a serious hurdle to reaching old age; abnormally low ones may indicate serious heart damage. If nothing else intervenes, you can be sure that this will be the cause of your death.

At this point you may well ask, when do we get to old age and what constitutes it? Well, for some it steals on softly like the approaching night, while with others it comes all too abruptly and unexpectedly. Perhaps at the very zenith of man's power he discovers that the tempo has changed; there comes the gradual flagging of his desires, of failing powers and progressive fatigue; in other words, the beginning of senescence. Most humans have a marked aversion to the acceptance of this, yet it is folly to be youthful unless you are young. A Chinese proverb says, "It is easy to die but difficult to die at the right time." "However, no road is the right one to him who knows not whither he goes."

Well, what are your chances? First you must look to your grandparents and great-grandparents. Your father and mother are too close to you biologically. It is indisputable that long-lived people most generally come from long-lived families. Then there are the circumstances of your life and their influence on your health. Your social and economic status, your youthful conduct, your habits, all are factors. Here it is a case of never too young to make preparations. To be sure it is not practical to choose your grandparents, but if you would grow old gracefully you must start "long range planning." The early formation of good habits, the overcoming of adverse tendencies, the conservation of that good circulatory system and stable nervous system are paramount. I could point out to you the most convincing scientific evidence that the moderate use of alcohol actually prevents hardening of the arteries. You could match this with the writings of eminent medical authorities who clearly state that it shortens life. Moderation must be the best counsel. Moderation also in eating, a well balanced diet. Meat? Certainly. Red or white? It doesn't matter; when it's veal, it's white, and when it's porterhouse, it's red. One is the calf, the other, the calf grown up into a steer. Shall we use sugar and sweets? Most certainly, in moderation and in the absence of obesity or diabetes. Above everything but oxygen, the heart must have sugar. The balanced diet should contain sufficient fat and all the vitamins and minerals.

As age creeps on, we notice that we need less and less food. Bodily growth has ceased, the furnace

needs less fuel; therefore the intake should be lessened and its character simplified. I blink a little when I see some old timer who has passed his biblical three score and ten, cover his raw oysters with horse radish and then dip them in the cocktail sauce. Exercise is important and desirable, but as the years advance, it should become more and more restricted. Those narrow coronary arteries cannot supply enough sugar to the heart to permit tennis for many. Golf and walking are the best forms to get you out into into the open air and sunshine. Even a wheelchair in the sunshine is better than being housed. Rest grows increasingly important. The repair processes are slowed down in the elderly. Early to bed and late to rise, with a nap after lunch, are good habits to acquire. The body weight must be watched. As a rule, the obese are doomed. Myself, I have long been looking for a fat old man of over eighty. Then there is that question of being graceful. Reducing, if necessary, must be done under expert medical advice. Medicine for reducing may be dangerous rather than helpful.

We must stress the importance of medical supervision for ageing people, blood pressure and heart examinations at regular intervals, careful checkup of urine. Foci of infection must be guarded against. Cancer, that dreaded disease of the aged, can in most instances be cured when found early enough.

Finally we come to the last few injunctions. There is nothing further that we can do about old age except to meet it with common sense and courage. Begin as early as possible to cultivate a hobby and a contented mind. I believe these to be the very basis of a happy old age. Keep your fingers busy, usefully if you can, but anyway busy. A garden is the perfect solution, a rose garden certainly the next thing to heaven. Now a last word about the help and consolation of religion in attaining a graceful old age. Why are churches visited so frequently by the aged? What comfort they derive from church going. Grow old we must, but growing old gracefully without the Grace of God must surely be difficult. Then I might remind you of what Browning has to say about it:

"Grow old along with me!
The best is yet to be,
The last of life, for which the first was made;
Our times are in His hand
Who saith, 'A whole I planned,
Youth shows but half; trust God; see all, nor
be afraid!"

THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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"DOCTOR"

Medicine, oldest of the professions, deals with the care and prevention of disease in the individual and with the promotion of public health and welfare. A physician is responsible for the life and death of his patients. He must have patience and perseverance, be a keen observer and be physically able to endure intensive study, tedious days, and broken nights. He undertakes to diagnose, treat, operate or prescribe for all human disease, pain, injury and deformity. He gives his time and energy freely to care for the sick and injured and to alleviate human suffering. As a public health agent he studies the cause of disease and premature death and applies his knowledge for the prevention of these conditions.

The actual time spent in securing a medical education is now longer than that of any other profession. Two or more years of premedical training in an arts and science college are required by the approved medical colleges; fifteen institutions require three years, three require a college degree for entrance to the medical school, and five schools require three years of college work for admission, with the additional requirement that the student must secure the baccalaureate degree on completion of one year's work in the medical school. Four years' training is required in the medical sciences, the most important of which are anatomy, physiology, embryology, chemistry, bacteriology, immunology, parasitology, pathology, pharmacology, and psychology. An additional year or more of hospital interneship is customary if not required, making the usual time consumed beyond high school graduation at least seven years of training.

Statutory requirements in all states now provide that to practice medicine in any state a doctor must be a graduate of a reputable medical school, and pass a licensing examination before a state or national board. In addition, a hospital interne year is required in 14 states, including Rhode Island. Certificates of the National Board of Medical Examiners are recognized in all but seven states. This board was organized in 1915 to establish in this country a standard qualifying examination of such a character that certificates awarded successful candidates could be safely accepted by all State boards of medical licensure as an adequate qualification for the practice of medicine. The Federal examination given to medical officers of the United States Army, Navy, and Public Health Service is also recognized by the licensing boards in most states. Except in Florida, Massachusetts, and Rhode Island, applicants who have passed licensing examinations in one state may, at the discretion of the examining board, be admitted without examination to practice in another state. In Illinois, Minnesota, and Oregon a practical or oral examination must be taken.

For devoted service, for the highest expression of generosity and good will, the physician occupies a place quite incomparable. No one should be allowed to practice medicine in this State unless his fitness is shown in documentary proof as prescribed by law. Neither should he be allowed to use the prefix "Dr." before his name or on his signs and stationery. The State of New York has enacted a law to this effect. It reads: "Section 1263—Penalties:—Medical Practice Acts, (b) Use in connection with his name, any designation tending to imply or designate him as a practitioner of medicine, or (c) Use the title 'doctor' or any abbreviation thereof in connection with his name in the conduct of any occupation or profession involving or pertaining to the public health or the diagnosis or treatment of any human diseases, pain, injury, deformity, or physical condition, unless duly authorized by law to use the same."

Rhode Island is overrun with quacks and charlatans who, after a six weeks course or after buying a degree, are using the name "doctor." The osteopath, naturopath, chiropodist, optometrist and numerous others are, as we are, "doctors." There should be a law in our State similar to that of New York for the protection of the public which, in many cases can not otherwise recognize that there is a difference.

ORGANIZATION

"It is hardly an exaggeration," said President Lowell of Harvard, "to summarize the history of four hundred years by saying that the leading idea of a conquering nation in relation to the conquered was in 1600 to change their religion; in 1700 to change their laws; in 1800 to change their trade; and in 1900 to change drainage. May we not say that on the prow of the conquering ship in these four hundred years, first stood the priest, then the lawyer, then the merchant, and finally the physician."

The medical profession has done more for the race than has ever before been accomplished by any other body of men. These gifts to the people have come in the form of vaccination, sanitation, anesthesia, antiseptic surgery, the science of bacteriology and the art of therapeutics.

No physician can ever be said to have finally mastered his profession. There is always something new to learn. He must keep eternally studying if he is to keep abreast of the times. There is probably no other profession in which so much work of this sort is required of the conscientious practitioner. His education never ceases.

The modern medico is the end-product of our present civilization. To paraphrase an earlier description, he must combine the finesse of a diplomat, the eloquence of a lawyer, the impartiality of a judge, the decision of a general, the frankness of a witness and the astuteness of a man on trial for his life, with the precision of a mathematician, the imagination of an artist, the altruism of a philanthropist, and, in money matters, the tenacity of a pawn-broker. While he tries to analyze the idiosyncrasies of the uneducated rich, who seem to be peculiarly liable to medical delusions, he is kept busy trying to keep the still more uneducated legislators from legislating him into the poorhouse. He must perhaps neglect the illness of some laborer who needs constant attention in order to coddle some convalescent melancholic who never was sick. He gets to see his wife and children every Sunday morning—whether they need it or not.

As servants of humanity we have a humanitarian service to perform which can be best accomplished by organization, cooperation and education.

The doctors of Rhode Island are regularly enlisted in an heroic army which is giving ceaseless and magnificent battle on behalf of suffering humanity. Our cause is a noble one. If it were pos-

sible to picture in one vast panorama all the deeds of a single day of those who devote their lives to fighting disease, mankind would, I believe, be thrilled by an emotion far more enduring than that which responds to the battle of destruction. And to the thoughtful mind how much more impressive —how infinitely more grand in all the elements of true grandeur—is the silent and sleepless contest to save human life, than the mad and cruel struggle to destroy it. Be not discouraged that our coming and going shall not be heralded by the blare of trumpets or the booming of cannon. Deep in the heart of the world there is growing a profound reverence for the thing we are doing.

POLIOMYELITIS IMMUNIZATION

The preventive measure against poliomyelitis, suggested by Dr. Max M. Peet, once at the Rhode Island Hospital, now Professor of Surgery at the University of Michigan, is receiving extensive clinical trial at Toronto.

Toronto, Ont., Sept. 2 — Five thousand Ontario children under 14 are being treated this week, in a vast clinical test, with the Peet zinc sulphate nasal spray — the most hopeful preventive measure yet discovered in the war against infantile paralysis. Fighting an outbreak which has made increasing inroads since June, and which is not expected to reach its peak until the third week in September, Ontario hospitals and clinics are giving this preventive treatment free to children — at the rate of 1,000 a day. Never tested conclusively since its recent development by Dr. Max Minor Peet of the University of Michigan, the value of the zinc sulphate spray as a preventive measure will soon be known as a result of the Ontario experiment.

"Ontario's experiment with 5,000 cases will be of the utmost importance to medical science," Dr. Thomas M. Rivers, director of the Rockefeller Institute Hospital of New York told a Toronto newspaper over long-distance telephone. Dr. Rivers said "that a picric acid spray, which has shown itself much inferior to the Peet spray in tests with animals, was used last summer on thousands of children in Alabama and showed some result, despite administration, in most cases, by sufficiently instructed physicians. The spray is certainly the most hopeful treatment so far," he declared.

Drs. Paul and John Rauch, staff members of the Hagmeier Clinic at Preston Springs, one of the Ontario institutions offering the free nasal spray treatment to children, declare that the spray, while not yet definitely proven a success in prevention of infantile paralysis, is "the only thing yet found of value as a preventive, and should be made a public health measure." Eight hundred children have been treated in five days at Hagmeier alone. The method of administering the spray, although requiring special training and instruction, is a simple one. Older children are treated with a nasal speculum and an atomizer. Younger children, somewhat more difficult to handle, are treated with an ordinary atomizer and then held upside down for a moment to allow the spray to penetrate to a sufficient depth into the nostrils.

Official sponsorship of the treatment was urged by Dr. Rauch. "I think it should be taken up as a voluntary measure," he said. "When an epidemic comes along, medical health officers are usually more aware of it than general practitioners, can give first-hand information and have the facilities. From the standpoint of statistics, it would be valuable, too, as the more we can centralize the treatment the better. The use of the zinc sulphate spray is not expensive, amounting to only a third of a cent per child. It could easily be handled by any civic health authority without financial drain. The main essential is some sort of pressure equipment. All hospitals have such electric pressure machines, and they are not expensive to install. The pressure machine is needed to enable the spray to reach an effective depth in the nasal passages.

"There is a point between the nose and the brain cavity, which is merely a thin plate of bone — the cribriform plate — with numerous perforations. As far as medical knowledge can substantiate, it is the only point at which the viruses of meningitis and paralysis enter the brain. As far as experimental work has shown, it is through the nasal passages that the paralysis virus enters. It lodges on the mucous membrane of the nose and thus enters the blood stream.

"The only scientifically conducted experiments with the nasal spray yet made—those with monkeys —resulted in producing immunity for about 80 to 90% of those treated, while 100% of the other group — untreated — got the disease. "Naturally, we do not hope for such a high percentage of immunization in children treated. But no matter what the percentage of cases successfully treated — we expect it to be between 25 and 50 per cent —

it would still be more than worth while." Reaction of the nasal spray treatment was sometimes swelling of the nasal membranes, headaches, and occasionally stomach sickness. "But this just lasts for a day or at the most two, and then passes off. The reaction is not nearly as bad as that of the picric acid in an alum combination which they used to use, and which was more astringent."

Value of the spray lasts only a comparatively short time, according to Dr. Charles F. Bolduan, public health education director for New York City. "But the treatment," he said, "is comparatively simple, if done by a competent man. It's by all means worth trying so long as it's done right. Dr. Peet's spray and method is by all odds the most hopeful thing we know of so far." Action of the spray is "simply a mechanical blocking of the olefactory nerve through which the virus gets up into the brain. It just prevents the nerve from letting the virus through."

Ontario's children and parents have responded to the offer of the free spray treatment by hospitals and clinics to such an extent that Toronto's city hospitals have speeded up clinics to take care of 1000 a day.

Old News

OUR MONTHLY DAILY

En Francais, le mot "jour" est dérivé du Latin "diurnum," mais depuis longtemps, "Journal" a été "Publication périodique qui donne les nouvelles politiques, littéraires, scientifiques, etc." English dictionaries are more strict in their definition of the word. Webster has it: "A newspaper published daily, or by extension, a weekly newspaper or other periodical publication," the Standard Dictionary: "A newspaper, strictly daily but used for other periodicals especially those that record news or events." The lay press appreciates the significance of the word. Our daily newspaper is a "journal." We have weekly news magazines, monthly reviews, annual reports. The entire number of weekly and monthly lay "journals" can almost be counted on the fingers.

Medical journalism is less critical. Nearly a half of all the weekly, monthly, and occasional medical publications are branded "journal." We like the name of our monthly daily and would not change it. At the same time we wonder why our own particular profession must be so shiftless in nomenclature.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the June Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Peter Pineo Chase, on Monday June 7, 1937, at 8:35 P. M. The minutes of the last meeting were read and accepted. The Secretary read an obituary of the late Dr. E. B. Smith. It was voted to spread this on the records and to send a copy to the family. The Standing Committee having approved their applications, the following were elected to membership:

Edward Bernard Medoff
Merle Mosier Potter
Lee George Sannella
Eugene L. Sielke

Dr. A. M. Burgess reported for a special committee, reading a letter signed by seven roentgenologists regarding X-ray examination of industrial employees and food handlers. Dr. Burgess also read a report of a special committee for the Standing Committee regarding a plan for adequate follow-up of persons found suffering from pulmonary disease and for examination of all tuberculosis contacts. It was voted to approve this report and send copies to the *Rhode Island Medical Journal* for publication.

The President announced the appointment of Drs. Cooney and Hindle as an obituary committee for the late Dr. George Reynolds. He also announced the appointment of Drs. Honan, Migliaccio, Winkler, Sawyer, and McCoart as a Golf Committee.

The first paper of the evening was entitled "Neurosyphilis—Survey of seven years treatment at the Chapin Hospital" and was presented by Dr. Hugh E. Kiene. The paper was discussed by Dr. Ira C. Nichols.

The second paper of the evening was entitled "Eye Manifestations of Tryparsamid Reactions" and was presented by Dr. William M. Muncy. The paper was discussed by Drs. Messinger and Kiene.

Dr. William S. Streker gave a preliminary report of the work and recommendations of the Committee on Re-organization. On motion of Dr. Clinton S. Westcott it was voted that this committee be continued.

The meeting adjourned at 10:20 P. M. Attendance 54. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D.,
Secretary

Report of a Special Committee of the Standing Committee of the Providence Medical Association, meeting with Dr. Edward A. McLaughlin and and Dr. John I. Pinckney

To the Standing Committee of the Providence Medical Association

Dear Sirs: —

At your invitation, the roentgenologists of Providence doing private practice met with you and the Rhode Island Director of Public Health on March 25, 1937, to consider the matter of X-ray examinations of industrial employees and food handlers. After some discussion the roentgenologists were requested to meet and to draw up proposals for giving such service. A meeting of the roentgenologists was held on March 31, 1937. As a premise to our proposal, we outline what might be termed a "credo," which we believe will be acceptable to all physicians and on which we base our action.

1. The examination should be adequate. In our opinion a minimum adequate examination should consist of fluoroscopy of the chest and one distance (six foot) film. This distance film presupposes the use of a machine which is powerful enough to register the required density in a sufficiently short time that the effect of the heart and diaphragm action is excluded.

2. The work is not properly one for a charitable hospital or organization. The subjects of the chest survey are employees or proposed employees of business firms organized for profit. Under the Workman's Compensation Act it has been established that the "accident risks of industry" are the responsibility of the employer. By broadening the Act to include certain aspects of health as related to employment, we believe the responsibility is also broadened. Charitable organizations are supported by contributions which include donations from physicians. If the examinations were to be done by a charitable organization, it would make the employer an unworthy recipient of charity.

3. There is a quasi public health factor in the situation. Certain suspected cases of infection, notably of tuberculosis, will be discovered and the patient as well as the general public will benefit. The example of the Wayne County Medical Society of Michigan, where many, if not most, of the immunizations are in the hands of the local profession, has given us a good idea of what may be done by private physicians along preventive and public health lines. We, therefore, propose as our contribution toward stemming the rising tide of State Medicine: —

That chest X-ray examinations, including film and fluoroscopy, of employees and prospective employees shall be done at an agreed minimum rate in consideration of the following facts; that they can be handled in considerable numbers at a time, that the examinations can be done at such special times that they will not interfere with the usual office routine, that the survey will be of large groups of people for a specific single purpose and that a minimum of supplies and stenographic work will be required.

(Signed) Simon Albert
Philip Batchelder
Emanuel W. Benjamin
James T. Boyd
Isaac Gerber
Russell R. Hunt
Jacob S. Kelley

After reading this communication from the roentgenologists and after discussion by Dr. Pinckney, there was general agreement by all present that the standpoint of the roentgenologists was well taken and that the work for industrial firms should be on a private basis as envisaged in their report. After considerable discussion the following suggestions were made: —

1. That the status of the X-ray man doing the type of industrial work under discussion being the same as that of the plant physician, he should consider it his duty to advise every patient in whom he discovers disease to consult his family physician.

2. That in case of persons in whom he finds evidence suggesting pulmonary tuberculosis, he should report the name of these persons to the State Board of Health, as required by law.

3. That it is the duty of the family physician in cases brought to his attention to avail himself of the appropriate agencies for the care of the patient and the study of contacts.

4. It is noted that the Providence Tuberculosis League agrees to receive for study patients of this group that are referred by a physician and only those so referred.

5. In the case of the examination of food handlers it is agreed that it is the duty of the examining physician to refer all patients found to be diseased to their private physicians, who should

then refer such patients to whatever private or public agencies they may deem appropriate.

The Committee recognizes that there are many details to be worked out. Among other things it recommends that suitable publicity be given to these recommendations so that all members of the Association may be reached.

Respectfully submitted,

William S. Streker, M.D.
Alex. M. Burgess, M.D.

Report of the Committee on Re-organization

The Committee appointed to consider the question of Re-organization makes the following recommendations: —

1. That the Standing Committee be enlarged, affording more complete representation in this committee which initiates practically all of the business of the Association and also acts as the nominating committee.

2. That the Providence Medical Association employ an executive secretary. This proposal is in keeping with present day trend in many progressive county and state medical societies. Considerable correspondence has been held regarding this question with the American Medical Association and with several county societies which employ executive secretaries. A recent exhaustive study was furnished by the American Medical Association. Opinion and comments were overwhelmingly favorable to the idea of employment of an executive secretary. An executive secretary would work with and under the direction of the Standing Committee, act as secretary of the various other committees, thereby correlating all of the Association's activities. The indications are that under this plan the activities of the Association would increase and become more efficient and effective. The Association would keep in touch with various health agencies which have progressed to wide development with little or no organized medical supervision or direction. Medico-economic problems and matters concerning public relations require more executive activity than the elective officers can be expected to perform.

Respectfully submitted,

June 7, 1937

Frederick J. Burns, M.D.,
Secretary.

Memorial Hospital

ALUMNI CLINIC DAY

Wednesday, November 3, 1937, will be Clinic Day at the Memorial Hospital. Last year the total attendance at Clinic Day, both for the morning and afternoon sessions, was about five hundred doctors, probably the largest clinic that has ever been held in Rhode Island. Preparations for the Clinic Day on November 3 are already well under way. The subject will be Diabetes. In the morning the different aspects of this condition will be presented by every department of the hospital. In the afternoon a symposium is to be given by a group of the professors of the Yale Medical School.

The program will include:

"Individualized treatment of diabetes," Dr. John P. Peters, Professor of Medicine.

"Extra-pancreatic diabetes," Dr. C. N. H. Long, Professor of Physiological Chemistry.

"The use and abuse of insulin," Dr. Paul H. Lavietes, Assistant Professor of Medicine.

"Surgery in the diabetic," Dr. Ashley W. Oughterson, Associate Professor of Surgery.

Notices will be sent later to all members of the Rhode Island Medical Society.

Dr. M. Walter Paydos has been appointed to the Out-Patient Department, Urological Service.

Plans are underway for a complete change of all x-ray equipment with larger quarters and facilities for x-ray therapy.

Woonsocket Hospital

The regular meeting of the Woonsocket Hospital Staff was held August 9, 1937, with Doctor T. Frank Kennedy presiding. Routine reports were submitted by the standing committees. Doctor N. S. Garrison gave an illustrated talk on "The Colon—Standard and Pathological." The lecture was most interesting and several members took part in the discussion.

The monthly clinical conference was held August 23, 1937. The first case was presented from the service of Doctor W. A. King. The diagnosis was not definitely determined and this case will come up for further discussion at the next meeting. The second case, one of "Hemorrhage from a Ruptured Ovarian Follicle," was presented by Doctor F. J. King. Several points were stressed in the interpretation of the symptoms, signs and clinical data.

Rhode Island Hospital

SCHEDULE FOR OCTOBER, 1937

Friday, October 1
New England Surgical Society
Morning Session
8:00 to 10:30 A. M. Operations
10:30 to 1:00 P. M. Clinics
1:00 Luncheon (Nurses Dining Room)
Afternoon Session
2:00 P. M. to 4:30 P. M. Lectures
(Nurses Auditorium)

Saturday, October 2
New England Surgical Society
9:00 A. M. to 12 noon
(Medical Library)

Friday, October 8
7:30 P. M. G. U. Staff Meeting
8:30 P. M. Surgical Staff Meeting

Mondays
10:00 A. M. October 4, 18
II Surgical Grand Rounds
October 11, 25
I Surgical Grand Rounds
4:30 P. M. Thoracic Clinic

Tuesdays
9:30 A. M. Gastro-Intestinal Clinic
10:00 A. M. October 5, 19
I Surgical Grand Rounds
October 12, 26
II Surgical Grand Rounds
12:00 noon October 12, 26
Clinical-Pathologic Conference

Wednesdays
10:00 A. M. Tumor Clinic
12:00 noon Skin Clinic

Thursdays
9:00 A. M. Orth. Grand Rounds
11:30 A. M. Thoracic Clinic

Fridays
11:00 A. M. Fracture Grand Rounds
October 15, 29
Pediatric Grand Rounds
11:30 A. M. Heart Conference

Saturdays
9:00 A. M. Neurological Grand Rounds
10:00 A. M. Medical Conference

Dr. David Freedman, who completed his residency on the Fracture and Orthopedic Service on September 1, is now resident intern at Truesdale Hospital, Fall River, Mass.

Dr. Thomas A. Martin's internship at the R. I. H. terminated on September 1. Dr. Martin, whose home is in Providence, is a graduate of Jefferson University Medical School. He is now stationed at Wallum Lake Sanatorium.

Dr. Alton Sherman, who interned at the R. I. H. from 1914 to 1916, visited the hospital on September 6th. He was accompanied by his wife and daughter. Dr. Sherman is doing general practice in Orange, N. J.

Dr. Russell Smith, intern at the R. I. H. from October 1932 to September 1934, is on a visit to the hospital. Dr. Smith interned at the Providence Lying-In Hospital after leaving the R. I. H. He is stationed at Price, Utah, doing general practice.

Dr. Robert R. Chace, of Providence, and a graduate of Yale Medical School 1937, started his internship at the R. I. H. on September 15th.

Dr. Alden W. Squires is the holder of a fellowship at the Lahey Clinic in Boston. He is now serving as resident in anaesthesia.

Dr. John T. Farrell, of West Warwick, is a patient in Ward E, R. I. H. He was recently visited by his son, Dr. John T. Farrell, Jr., of Philadelphia, Pa. Dr. John, Jr. interned at the R. I. H. in 1922 and 1923.

Dr. Arthur Harrington has been a patient in Ward E., R. I. H. He is now convalescing at his home at 81 Elmgrove Ave., City.

On November 12th and 13th there will be held in Boston the annual combined meeting of Region One of the American Academy of Pediatrics, and the New England Pediatric Society. The program is not yet complete but it is sure to be of the highest quality and to cover subjects of especial interest.

The New England Pediatric Society is composed of pediatricians and general practitioners interested in pediatrics. Formerly the meetings were monthly with a small attendance; for the last few years there have been three or four meetings a year, the programs have been fine and the meetings well attended. Any physician who would enjoy such meetings should inquire about this society from the secretary, Dr. Henry E. Gallup, 66 Commonwealth Avenue, Boston, Mass.

The first West Coast meeting of the American Academy of Orthopaedic Surgeons will be held on January 16-20, 1938 at the Hotel Biltmore, Los Angeles. Special trains will be run with stop-overs at Santa Fe, the Grand Canyon, San Francisco and other points. For further information write to Robert L. Lewin, Hotel Biltmore, Los Angeles, California.



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Next Annual Meeting, June 1-2, 1938

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Reports on Medical Care of the Low Income Group, Reorganization of the Providence Medical Association, Meeting of the New England Surgical Society.

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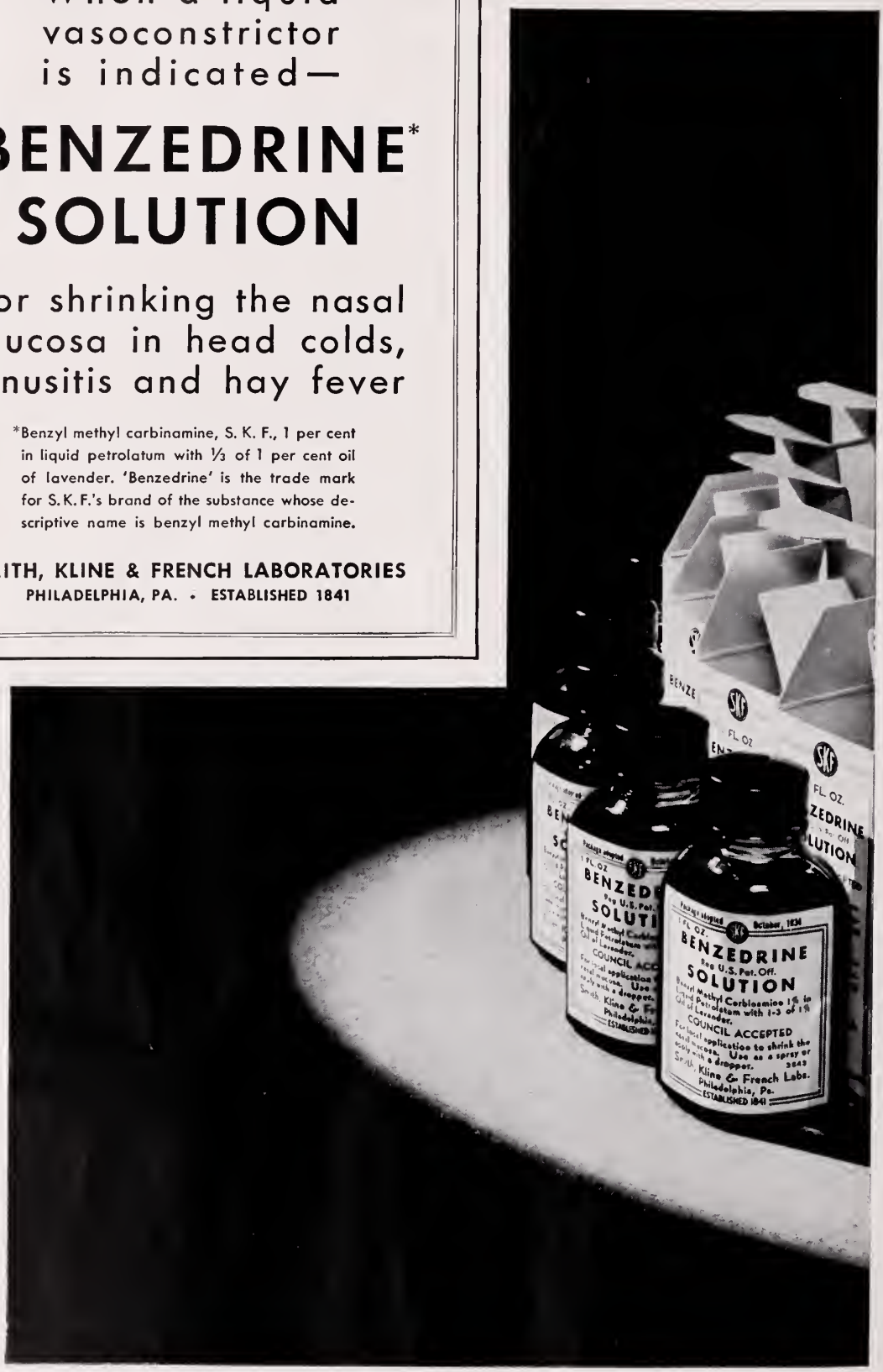
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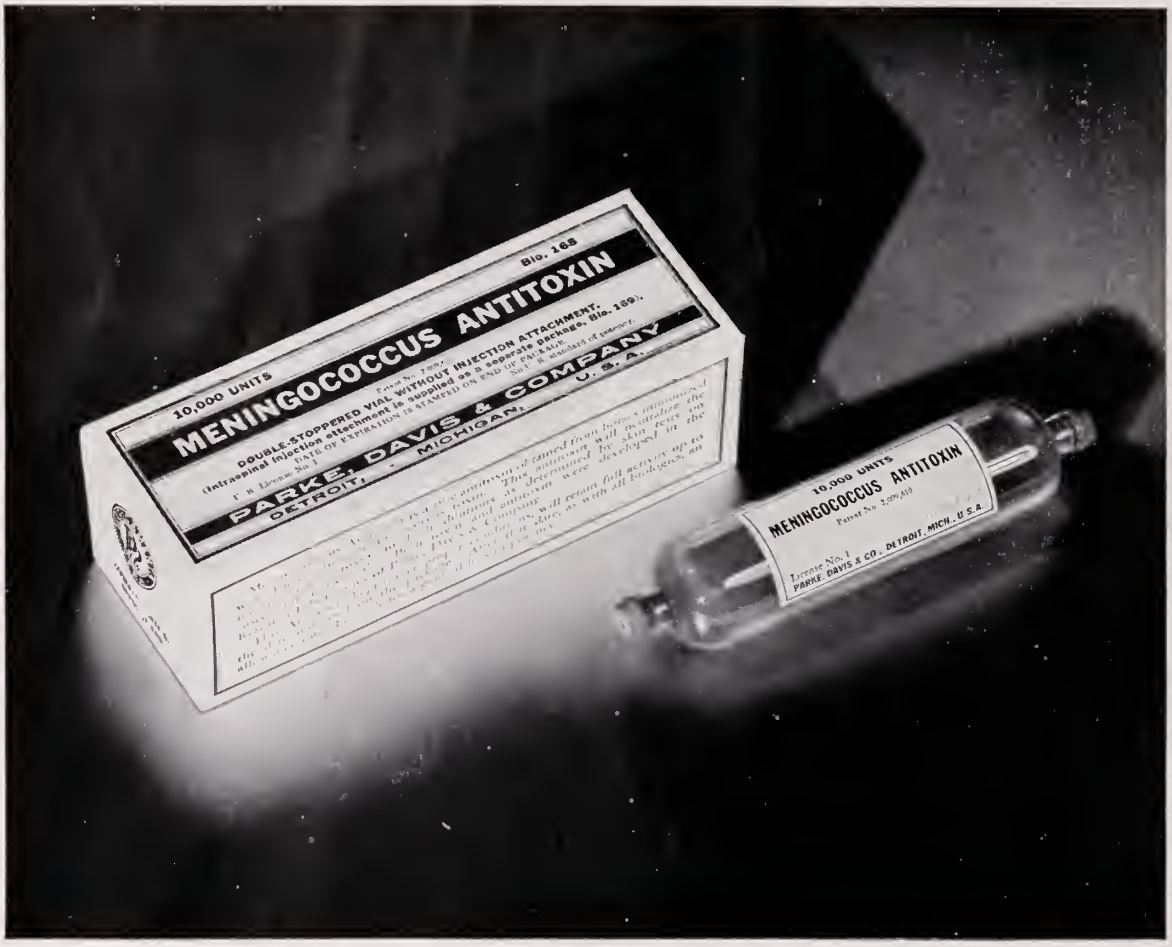
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(1) 1935. The Lancet 228-I, 71
(2) 1936. Am. J. Med. Sci., 191, 319
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(5) 1937. The Avitaminoses Eddy and Dahldorff William and Wilkins Baltimore
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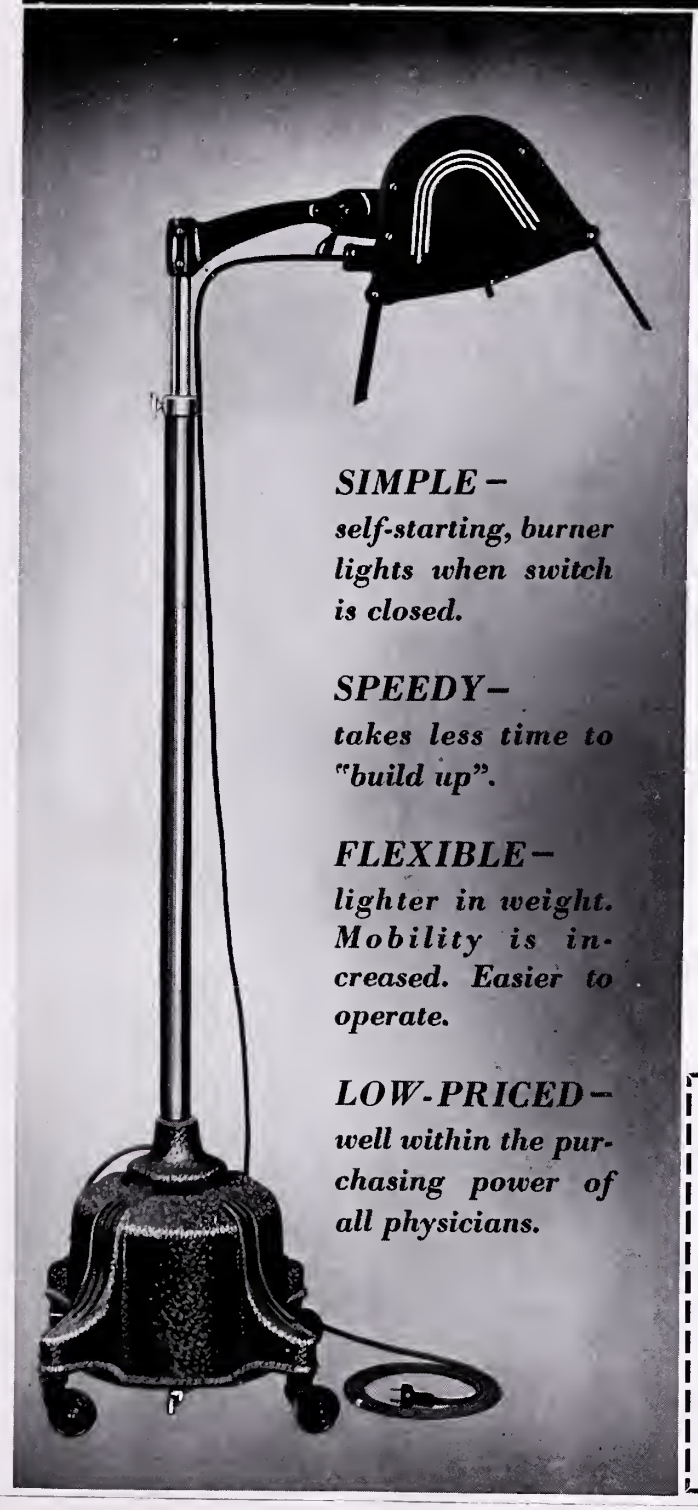
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"As to the kind of extra carbohydrate to be added, whether lactose or maltose, I believe dextri-maltose to be better in general in cases of fat indigestion (infantile atrophy)."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, V. 1, p. 418.*

In the treatment of decomposition, "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—*E. Feer: Text-Book of Pediatrics, J. B. Lippincott Co., Phila., 1922, p. 284.*

In infantile atrophy, "The carbohydrate should be increased by gradual addition of dextrimaltose.

"Malt soup or dextrimaltose (Mead's) should be added in teaspoonful or more doses to each feeding until the point of carbobydrate tolerance is reached."—*L. Fischer: Diseases of Infancy and Childhood, F. A. Davis Co., Phila., 1925, V. 1, p. 285.*

In tbe case of a premature infant, "Dried milk with water was given, which later was changed to whole milk, 14 ounces; water, seven ounces, and dextri-maltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. The above feeding was retained. The infant gained eight ounces at tbe end of the first week."—*L. Fischer: Clinical notes in a series of premature infants, Arch. Pediat. 44:227-231, April, 1927.*

In the treatment of decomposition, "As a rule it is best to start witb 2 to 2½ or 3 ounces of albumin milk to tbe pound weight in 24 hours; tbe sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—*C. G. Grulee: Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 265.*

With reference to hypotrophy, "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritional disorders in artificially-fed infants, New York M. J. 114:158-160, August, 1921.*

In athrepsia, "The carbohydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weigbt are added."—*J. H. Hess: Feeding and the Nutritional Disorders in Infancy and Childhood, F. A. Davis Co., Phila., 1928, p. 278.*

Concerning tbe treatment of marasmus, "When tbe stools have become smooth and salve-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—*L. W. Hill: Practical Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 281.*

In the feeding of prematures, "As soon as there is a hesitation in the gain in weight, dextrimaltose No. 1 is substituted for the dextrose, in the same amount in the mixture, with almost invariably a gain in weight."—*F. B. Jacobs: Relation of irradiated food substances and ergosterol versus cod liver oil in childhood nutrition, Pennsylvania M. J. 35:164-167, Dec., 1931.*

"A spasmopbilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—*M. Jampolis: Infantile spasmophilia, Interstate M. J. 25:652, Sept., 1918; abst. Arch. Pediat. 35:691, Nov., 1918.*

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'dextri-maltose,' for the extra carbohydrates; . . ."—*M. Ladd: Further experience with homogenized olive oil mixtures, Arch. Pediat., 33:501-512, July, 1916.*

In pyloric stenosis, "With low dextrose tolerance, a maltose dextrin preparation may be added in whole or in part. Even where the dextrose is well tolerated and gain in weight has ceased, impetus to the weight ontake may be given by the addition of a maltose dextrin preparation."—*D. J. Levy: Pyloric stenosis and pylorospasm of infancy with especial reference to medical treatment, J. Michigan St. M. S., 21:166-170, April, 1922.*

With reference to the treatment of diarrhea, "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—*F. Lust: The Treatment of Children's Diseases, J. B. Lippincott Co., Phila., 1930, p. 145.*

In dyspepsia, "The carbohydrate must not be allowed to exceed 3 per cent. Dextri-maltose is the most suitable sugar."

In tbe treatment of decomposition, atrophy, malnutrition, marasmus), ". . . when there has been obvious improvement, dextri-maltose is gradually increased from 3 to 5 per cent."—*B. Myers: The nutritional disturbances of infancy, Brit. M. J., 1:1079-1083, June 21, 1924.*

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—e.g., dextrimaltose."—*L. G. Parsons: Wasting disorders of early infancy, Lancet, 1:687-694, April 5, 1924.*

In the milder cases of inanition, "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—*W. J. Pearson and W. G. Wyllie: Recent Advances in Diseases of Children, P. Blakiston's Son & Co., Phila., 1930, p. 116.*

In intestinal intoxication, "I have had more experience with dried skimmed milk in which 2 to 5 per cent dextrimaltose, barley or rice flour has been cooked, and the mixture subsequently fermented by lactic acid bacilli or soured with lactic acid, than with any other food except protein milk."—*G. F. Powers: A comprehensive plan of treatment for the so-called intestinal intoxication of infants, Am. J. Dis. Child., 32:232-257, August, 1926.*

Regarding the treatment of the marantic infant, "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—*C. S. Raue: Diseases of Children, Boericke & Tafel, Phila., 1922, p. 427.*

In spasmophilia, "Dextri maltose is the best sugar to use in these cases, in the proportion of 6 to 8 per cent."—*J. H. Reading, Jr.: Spasmophilia, Hahneman. Monthly, pp. 403-411, July, 1922.*

In the treatment of atrophy, "If the baby continues to improve, the next step in tbe treatment is to add to the milk one of the less fermentable carbobydrates, such as dextrimaltose; . . ."—*H. Thursfield and D. Paterson: Diseases of Children, William Wood & Co., 1929, p. 105.*

"I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired; in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding; Its Principles and Practice, Lea & Febiger, Phila., 1915, p. 158.*

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—*J. H. West: Low fat, high starch evaporated milk feeding for the marasmic baby, Arch. Pediat. 48:189-193, March, 1931.*

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—*O. H. Wilson: The role of carbohydrates in infant feeding, Southern M. J. 11:177, March, 1918; abst. Arch. Pediat. 35:447, July, 1918.*

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THE RHODE ISLAND MEDICAL JOURNAL

Issued Monthly under the Direction of the Publication Committee of the Rhode Island Medical Society.

VOLUME XX
NUMBER 11 | Whole No. 338 | NOVEMBER, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

OPHTHALMIC REACTION TO TRYPARSAMIDE IN THE TREATMENT OF NEUROSYPHILIS

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In January, 1934, I was relieved from routine duties as ophthalmologist at the Charles V. Chapin Hospital to take charge of the examinations of the cases of neuro-syphilis. This seemed necessary due to the fact that, although the treatment of these patients by tryparsamide produced most favorable results, there was ever present the fear of impairment of vision from the special affinity of this drug for the optic tracts. Are there any indications to be found by examination of the eyes that would cause one to suspect such a reaction? A survey of the literature on this subject still leaves one in a quandary.

Behr lists four counter-indications to its use: 1. Diminished central vision, loss of color fields with normal or almost normal form fields. 2. A high degree of concentric contraction of form and color fields with central vision normal. 3. Transient visual disturbances, more in form than color, although central vision is good. 4. Subjective complaint of photopsia. Our examinations have shown that if the above rules are applied, practically all of the cases that are most urgently in need of this drug would be denied its benefit. Lillie has pointed out that it is the failure to take visual fields and a lack of previous knowledge of the various changes that have been going on in the eye that has lead many to attribute all ocular symptoms after its administration to be directly caused by tryparsamide. Too frequently it is but the continuation of pathological processes already far advanced. Fouche has stated that the optic atrophy of tabes or general paresis is always progressive and although its advance to complete blindness is slow, it is always sure. In the face of these and many other conflicting views, it was our task to try to establish some kind of practical working rule for the handling of these cases. I regret that although we have been over three years, the solution is not yet at hand although we have had many interesting subjects to study. However, certain trends of thought have been established.

Our system consisted in first examining the eyes as to motility, pupilary reflexes, media and fundus, then the central visual acuity with and without glasses, lastly the form and color fields. If possible all this was done before fever therapy and again preceding the administration of tryparsamide. If the patient was non-cooperative the examination was as extensive as could be and later attempts to finish the records were made as the patient improved. During the period of the first ten treatments, special care was taken to note any changes in the eyes. If there were none they were given the routine examination every six months. In all, one hundred cases of neurosyphilis were examined, of whom forty received tryparsamide.

All cases having a plus Wassermann spinal fluid, with one exception, had contracted color fields within recognized pathological limits. The one case which was lacking in this particular was also negative to all signs and tests of brain syphilis. Was it possible that the spinal cord was affected prior to any changes in the higher centres? So consistent was this situation found to be that even the cases which had long since been made spinal negative by treatment still retained the contracted color fields. A few cases which showed improvement of their color fields under treatment never went entirely back to normal. As a number of cases with blood plus Wassermann and spinal negative showed contracted color fields the question arises whether they are not potential cases of neuro-syphilis. This lead me to make the assertion, in 1934, that the presence of a contracted color field in a blood syphilis case which condition can not be accounted for by any other cause, is a presumptive sign that the brain is

Read before the Providence Medical Association at the meeting on June 7, 1937.

becoming involved.* It is surprising to learn how many cases of neuro-syphilis show no other ocular sign. Next in frequency is the so-called Argyle-Robertson pupil, appearing in one or both eyes. A number having apparently normal fundi presented contracted form fields to a slight degree. This was almost always a small border segment in the upper, outer, temporal quadrant in one or both eyes, which loss was sometimes regained during treatment. Unless there was some visible lesion in the retina, choroid or nerve, there was no diminution in central visual acuity.

Out of our series of 40 cases having tryparsamide, five had their eyes affected during treatment. A sixth was picked up on routine six months' examination which showed changes that could not be attributed to any other cause. This raises our percentage of eye reactions to 15. Five of these cases had, prior to reaction, good central vision, normal form fields and nothing on ophthalmoscopic examination that would indicate any disease of the tissues viewed. On the other hand patients with old iridic adhesions, retinitis of arterio-sclerotic origin and even tabetic atrophy were thus treated, without harm. In fact I am sure that in some of these the progress of the disease has been arrested. The one disastrous result was in a patient having a syphilitic retino-choroiditis with greatly contracted form fields. Here there seemed to be a definite counter indication; yet another case, blind in one eye and fast losing the other, has been held in check up to the present time. Five of the group had Argyle-Robertson pupils but one reacted to light and accommodation.

The symptoms produced by tryparsamide shock reaction are intensely subjective. The patients complain of colors, dust or fog before the eyes. There is a marked nervous condition with a feeling of uncertainty in going about. Frequently on examination, the central visual acuity is found to be normal or at least the same as it had been for a long time prior to the complaint.

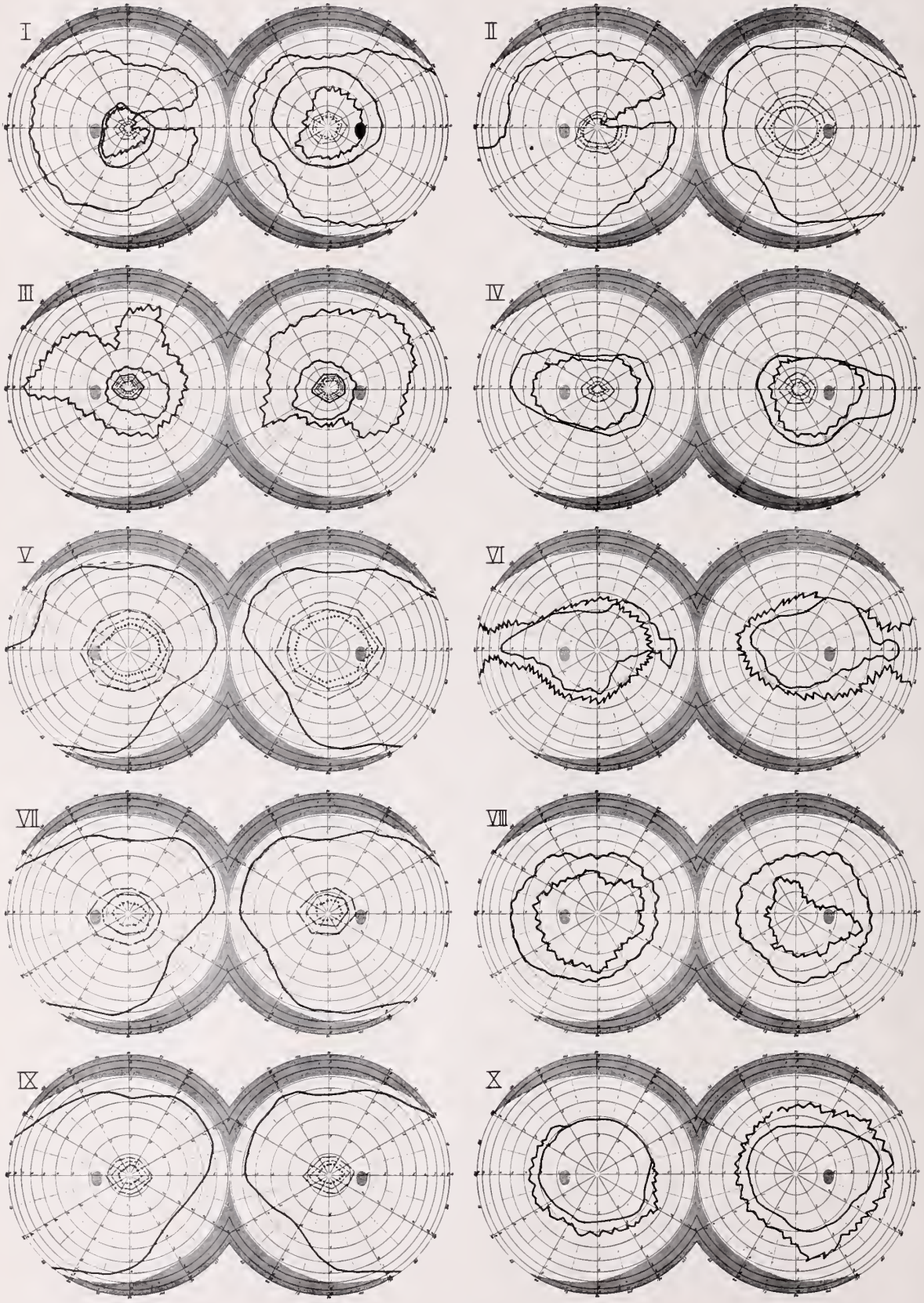
As far as the media and eye grounds were concerned, there was nothing different from that found on previous examinations. In the histories which follow I have quoted other members of the staff whose examinations verify this point although it seems to be in opposition to some observers. On taking the form fields one discovers a marked contraction in comparison with that of the previous records. This, if the examination is early, generally continues for a few days when slowly an improvement is noticed. This improvement continues until a final stationary point is reached but never fully back to the previous state. I have never seen the color field further contracted from its original position unless the form field was so choked down that it reached the color territory when it, as well as the perception of form, was lost; and again central visual acuity seems to be little touched unless the contraction of the form field encroaches upon the fovia centralis, when all may be lost. Some severe reactions allow 20/20 or even 20/15 vision.

We agree with other observers that the reaction is apt to come during the first ten doses. Two of our worst were after the second dose while the next most severe followed the fifth. The two least affected were after 8 and 16 treatments respectively.

Therefore we are forced to conclude that there are no indications by which one might expect to obtain an ophthalmic reaction from the use of tryparsamide. The most that one can say is that there seems to be an individual idiosyncrasy or allergic susceptibility to this drug in certain individuals. If one does get a reaction in the presence of an already contracted form field grave results are to be expected. However, the presence of such a contracted field is no evidence *per se* that bad results are to follow this treatment. Such deductions as above made on so small a number of cases over but a three year period cannot be conclusive but rather point the way for further studies.

The excellent results obtained in treating neuro-syphilis in the early stages by fever therapy followed bytryparsamide should stimulate further endeavor to obtain frequent spinal fluid analysis in all cases of blood syphilis. May I raise the question whether, in the presence of a positive blood and a negative spinal fluid and a contracted color field, the patient might be considered a potential neuro-syphilis case? Further, after a careful survey of the history, would not fever therapy followed by tryparsamide place this treatment in the field of preventive medicine, thereby reducing the dreaded brain syphilis to a minimum? It is at least demonstrated that a much closer cooperation between the ophthalmologist and the syphilologist must be established if these cases are to receive proper care and especially is this true if an early diagnosis of neuro-syphilis is to be made

*Muncy, William M.: Contraction of the Color Fields in Neurosyphilis, R. I. Medical Journal, XVIII, p. 9. January, 1935.


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or tryparsamide, the most beneficial drug for its treatment, is to be administered. I will now briefly review the 6 cases which reacted adversely to tryparsamide, they being the major source of the material for this paper.

Case I.

Mr. E. S., age 52; diagnosis, tabes.

Dr. Messenger's examination of the eyes on November 14, 1934, was as follows: "pupils are small, left being larger than the right. They react to accommodation but not to light. Findings are otherwise normal." This patient was given a course of therapeutic malaria followed by two doses of tryparsamide, 3 grams each. Complaining of failing vision and spots before his eyes, he was sent to me for examination on January 2, 1935. I found the pupils did not react to light, the media clear, fundus apparently normal with a vision with glass correction of 20/30 in each eye. Fields were found to be as in Chart 1, straight line. Examinations were made almost daily as the fields became smaller until the 9th, (see Chart 1, zigzag line), from which time they continued to improve until August 27, 1935 (see Chart 1, waved line). On September 25, 1935, tryparsamide was resumed. There was no reaction noticed although for a long time frequent examinations were made. He has had since then to date 52 doses of 3 grams each. The patient is in excellent health, working every day. Chart 2, made May 18, 1937, will not only show the present state of his form fields but also enlarged color fields.* The visual acuity was normal in the right and 20/30 in the left eye.

Case II.

Mr. M. S., age 37; diagnosis, general paresis.

After admission he had therapeutic malaria. Dr. Hacking's examination was as follows: "pupils equal, do not react to light direct or consensually but react to accommodation. Lens and media clear. Disc outlines clear and well defined. Arteries and veins within normal limits. Retina shows no hemorrhages or exudates." My examination on May 3, 1934, was similar. The vision was found to be ½ of the 20/20 line in the right eye and 20/20 in the left eye. Form fields were normal but markedly contracted color fields were present. After 5 doses of 3 grams of tryparsamide he complained of poor vision and ran into objects when going about (tubular vision). Dr. Hacking's examination at this time, June 13, could find no objective evidence of any eye pathology. Making my examination on the 16th, I could find no vision defect in the media or retina. The central visual acuity was the same as when first examined but the form fields had contracted down to the original color fields, which in themselves were not changed (see Chart 3, straight line). The patient refused to stay at the hospital although his form fields had tripled in size by the 20th of June, the date of his departure (see Chart 3, waved line). However on June 4, 1935, a year later, I induced him to come to my office where the last examination was made. Vision was then 20/20 in both eyes. Although the color fields were still the same as originally, the form fields were so enlarged that he drives an automobile at his occupation as salesman for a motor oil company (see Chart 3, zigzag line).

Case III.

Mr. H. M., age 36; diagnosis, tabo-paresis.

Was transferred to the house May 29, 1936, and I examined him on the 9th of June. His pupils were unequal, the right being larger than the left. They did not react to light but reacted to accommodation. The lens and media were clear. Vessels appeared attenuated with discs pale, especially on the temporal side. The right eye had many small, discrete, yellowish-white exudates scattered throughout the fundus, especially in the periphery. The left eye showed a few of the same exudates in the outer temporal side. The vision was 20/20 which with a slight glass correction could be brought to 20/15. He was given typhoid antibodies treatment, followed by two doses of tryparsamide, when he complained of visual disturbances. His form field prior to treatment was as Chart 4, straight line, but his examination at this time, June 23, showed further contraction to Chart 4, zigzag line. His central acuity was still 20/15. His vision continued to fail and on August 10, 1936, he was admitted to the State Infirmary, having become blind. The fact that this was a case of syphilitic retino-choroiditis may have had some relationship to the result. We have given tryparsamide to other cases of retinitis and choroiditis without harmful results, in fact one case with a blind left eye and a rapid progression in the right eye, which had contracted down to 20° with a visual acuity of 3/200, has apparently been kept stationary under tryparsamide treatment. The rule still holds, nevertheless, that if fields already markedly contracted are further encroached upon, severe lasting damage must be expected.

* Dot and dash line blue, dash line red, dotted line green.

Case IV.

Mr. C. K., age 51; diagnosis, general paresis.

First examination was made June 2, 1936, when vision, with glass correction, was found to be 20/20. Left pupil smaller than the right, does not react to light but reacts to accommodation. The color fields are very large for a neuro-syphilis case, although still pathological. The form fields are within normal limits but there is a conspicuous contraction in the upper temporal quadrant of the left eye. This contraction was the same for various sized test objects (see Chart 5). On August 11, after eight tryparsamide treatments of 3 grams each, he suddenly complained of poor vision and uncertainty in getting about. His central vision was found to be the same as above but his form fields were much contracted (see Chart 6, straight line). The visual fields continued to enlarge slowly until they had extended along the median line temporally on each side, thus improving materially his ability in walking (see Chart 6, zigzag line). On February 2, 1937, he was given one gram of tryparsamide for three doses when three gram treatments were resumed. Up to May 18, 1937, he has had nine of these without any untoward results.

Case V.

Mr. A. F., age 51; diagnosis, tabo-paresis.

No fever therapy was given on admission because of his poor health. On examination, October 6, 1936, vision in the right eye without glass correction was 20/30 and in the left eye, ½ of the 20/20 line. Pupils were small, even, but did not react to light. Normal reaction to accommodation. The form fields were normal with color fields contracted down to between 15° and 10° (see Chart 7). After 16 treatments with tryparsamide he complained of specks before the eyes. On December 12, 1936, he showed an acuity of vision of ½ of the 20/30 line but with contraction of the form fields in both eyes. This continued until the greatest damage was recorded on February 5, 1937 (see Chart 8, zigzag line). He was readmitted to the hospital January 5, 1937, under the diagnosis of general paresis, and fever therapy was administered. Eye examination by Dr. Grossman, "Pupils small and rigid to light, react to accommodation. Argyle-Robertson discs pale, fundus otherwise normal." April 18, 1937, I find the above correct with a vision of 20/30 in the right and 20/20 in the left eye and a considerable enlargement of the form fields (see Chart 8, waved line).

Case VI.

Mr. A. C., age 53; diagnosis, general paresis.

Was first examined May 28, 1934. Vision with correcting glasses of 20/20, pupils reacted to light and accommodation, media was clear and disc well defined and normal, nothing abnormal in the retina. Form fields were found to be normal but with color fields contracted to 10° and less (see Chart 9). Therapeutic malaria was given followed by tryparsamide in August, 1936, ending a series of 70 treatments. Routine examination, November 17, 1936, showed marked contraction of the form fields which continued to January 12, 1937 (see Chart 10, straight line), when it became stationary and improved later to May 18, 1937 (see Chart 10, zigzag line) with vision still 20/20. The media and the retina appeared normal. In view of the findings and the similarity of this case to those previously reported I can attribute the condition to no other cause than a reaction to tryparsamide. Either the visual changes failed to produce subjective symptoms sufficient to cause the patient to complain or, what is more likely to be the case, his inability to speak English readily, combined with phlegmatic disposition, let the effect of the contracted field pass unmentioned.

THE MODERN TREATMENT OF NEUROSYPHILIS

Hugh E. Kiene, M.D.
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There have been 162 cases of neurosyphilis admitted to the psychiatric wards of the Charles V. Chapin Hospital from June 1, 1930 to January 1, 1937. Of this number, sixty-five or 41% are definitely improved and able to adapt themselves outside an institution; forty patients or 24% have not improved sufficiently to adjust in the community; and fifty-seven or 35% have died since their first admission to the psychiatric wards. This survey comprises all types of neurosyphilis admitted—cases of paresis, tabes, tabo-paresis, and cerebral lues; it includes far advanced demented patients and those whose general physical status was extremely poor; it takes into consideration both treated and untreated cases.

Going back a relatively few years, before modern treatment of neurosyphilis was instituted the mor-

tality was practically 100%. Now it is reliably stated that almost 100% can be cured. The following tabulation shows continuous improvement in the results of treatment:

	Total	Unimproved		Improved		Dead	
	No.	No.	%	No.	%	No	%
1930	9	4	44⅔	2	22	3	33⅓
1931	18	8	45	2	11	8	44
1932	32	6	20	14	42	12	38
1933	37	9	26	12	30	16	44
1934	15	3	20	9	60	3	20
1935	26	8	32	8	30	10	38
1936	25	2	8	18	70	5	22

These figures will not tell the whole story as some of the later cases will show a change in status, some will die and others may eventually require institutional care. It is believed, however, that as the medical profession continues to make earlier diagnoses, treatment can be begun sooner and the percentage of discharged patients will therefore be higher.

Because of its severity, it has been difficult to administer adequate treatment in some cases. There are those who are not strong enough physically to tolerate the high fever necessary. Certain eye findings, also, contraindicate the use of tryparsamide, the drug of choice following fever therapy. Of those patients in our series having adequate fever treatment of eight or more elevations in temperature above 103° Fahrenheit, twenty-four or 60% were of the unimproved group; twenty-two or about 40% of the group died; and fifty-one or about 77% improved. At least twelve weekly injections of tryparsamide have been given to twenty-two patients comprising 55% of the unimproved group, fifty-seven or 87% of the improved group, and three cases or 5% of the group that died.

There have been difficulties in making this review complete as patients who show improvement tend to neglect their treatment and can not be followed. At present, with a full-time social worker in the Neuropsychiatric Out-Patient Clinic, follow-up in all cases is possible.

Treatment used on the psychiatric wards of the Charles V. Chapin Hospital consists of induced fever. In the first method the patient is inoculated with tertian malaria and allowed to have as many paroxysms of fever as his physical condition permits. The malaria is given either intravenously or intramuscularly and the time required for this part of the treatment is from four to six weeks. Before inoculation, the patient must have a complete physical study and during the fever he requires careful medical observation. Usually it is easy to terminate the malaria by giving quinine. Malarial therapy has been proved satisfactory wherever it has been in use. There are certain disadvantages; namely, the patient is given a disease; the malaria is toxic and can not be given to debilitated patients; and chronic malaria may follow the treatment course.

The second method, which has been introduced by Dr. Marque O. Nelson of Tulsa, Oklahoma, substitutes typhoid vaccine injections for malaria, in order to produce the desired fever. His procedure consists in giving divided doses of the vaccine to produce a febrile reaction of 103° Fahrenheit or better. To begin the treatment, 25,000,000 dead typhoid bacilli are given intravenously and the patient's temperature, preferably rectal, is taken every half-hour until a rise is noted. Then the temperature is taken every fifteen minutes until it again becomes normal. This first injection is a test reaction and often gives a fever of 103° Fahrenheit without the need for a second injection. On the second day of treatment, the amount of vaccine is doubled and the temperature again recorded. On the third day it is advisable to give an initial dose of 25,000,000 bacilli intravenously and follow this in one and a half hours with 50,000,000. As the treatment progresses, the dose is gradually increased from day to day by approximately 25,000,000 so that on the fourth day of treatment the initial injection is 50,000,000 and the second injection 100,000,000, or double the first. As long as the febrile reaction is well above 103° it is unnecessary to increase the dosage. There is a wide margin of safety in this method of treatment and doses of 500,000,000 and 1,000,000,000 have been given without harmful effects. After ten to fifteen febrile reactions above 103° have been given, the treatment is stopped. At the Chapin Hospital we have used typhoid vaccine with twenty-one patients. Of these, fifteen are now improved, five have died since the treatment and one is unimproved. This series is not large enough to allow conclusions.

Whether typhoid vaccine or malaria is used to produce the fever, careful nursing care is extremely important. Prevention of constipation by means of enemas and forcing fluids to at least 125 to 200 ounces daily, is of primary concern. Between paroxysms of fever the non-debilitated patient may be up

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Read before the Providence Medical Association at the meeting on June 7, 1937.

Hugh E. Kiene, M.D.; Physician in charge of the Psychopathic Department of the Charles V. Chapin Hospital.

and about. Tryparsamide is the preferred drug in the follow-up treatment but is given only after careful examination of the eyes. After the approval of the oculist, tryparsamide is given in doses of 3 grams once a week. The number of treatments depends not only on the patient's symptoms, but also on the spinal fluid serology (Wassermann, cell count, Pandy and gold curve), which must become entirely negative before a cure is effected. There are many other methods of producing fever, including diathermy, radiothermy and a new air-conditioned hot box.

In all cases of syphilis admitted to the psychiatric wards of the Chapin Hospital, members of the patient's family are given routine blood Wassermann examinations. If the blood Wassermann is found positive, a spinal fluid examination is recommended. In this way, several latent cases of neurosyphilis have been discovered and treated, in the husbands or wives of our patients. This indicates that certain strains of the spirocheta pallida may have a predilection for the central nervous system.

To cite examples of fever therapy and the importance of early treatment—a seven-months-old female child was brought to the hospital with the following complaints — a nasal discharge, dry cough, five loose greenish stools a day, frequent vomiting after her bottle, irritability and crying almost continuously. The admission diagnosis was meningitis. Examination of the spinal fluid at the hospital disclosed a strongly positive spinal fluid Wassermann and a high spinal fluid cell count, indicating an active luetic meningitis. For this the child was given typhoid vaccine into the longitudinal sinus, ran a satisfactory febrile course and showed a rapid clearing of the acute symptoms. Examination of the spinal fluid several months later found it practically negative and the child has been in good health since.

The second patient is a man thirty-eight years old, who had a chancre in 1934 and was treated with neosalvarsan and mercuric salicylate. In 1936, after considerable treatment, his blood Wassermann was found doubtful. A spinal fluid examination was done at this time and revealed a Wassermann ++++ with both acetone and cholesterol. He was treated with fever and later with tryparsamide. On April 21, 1937, his spinal fluid Wassermann was doubtful and the other spinal fluid findings greatly improved. In this case, the patient was given adequate treatment for systemic syphilis. When the spinal fluid Wassermann was found positive he was given treatment for neurosyphilis, consisting of fever and tryparsamide. The treatment was instituted before mental symptoms developed. The spinal fluid has shown a marked improvement following the treatment and now, in less than a year, is practically negative. It is interesting to observe in this patient that the invasion of the central nervous system by the spirochete occurred less than two years after the primary lesion.

The third patient also was a man thirty-eight years old, who had his chancre at the age of twenty at which time he consulted a physician and was given arsenicals and bismuth. The exact quantity is not known but the amount given may be judged by the expense of the treatment to the patient, which totaled $400.00. His physician made repeated blood Wassermann tests which were all found negative, so he discharged the patient as cured. In 1933, many years after he had been discharged as cured, the patient wished to marry and wanted a clean bill of health. He consulted his physician and was advised that it would be perfectly all right to be married. Three years after his marriage a change was noticed in his behavior. His wife stated that she observed his judgment was impaired when driving his car; he seemed to lose strength in his hands and dropped things; he was unusually cheerful at his work, singing and humming; he rambled when talking; he refused to associate with people and he said he had made 33 billions through stock, colored pictures and by working. It is needless to say that on admission to the hospital he was found to have neurosyphilis. Typhoid vaccine was given as previously outlined. His response to this was remarkable and after nine weeks in the hospital, he was able to return to his former employment.

After observing neurosyphilis and its effects, one is impressed by the number of cases which have not been treated early enough. Treatment has been proved efficacious and curative. In order to achieve the best results, treatment must be undertaken before the spirochete has caused extensive damage to the brain and spinal cord. Once destroyed, the neurons of the central nervous system do not regenerate so that a cure in the advanced case of neurosyphilis merely results in eliminating syphilis from the body and not in restoring the individual's mental and intellectual ability. For this reason, treatment of primary and secondary syphilis is important. The drugs of choice, in a general way, consist of

arsenic and bismuth preparations given intravenously and intramuscularly. Treatment is concerned with eliminating the patient's symptoms and in clearing up the blood serology.

From the standpoint of prevention of neurosyphilis, the physician should not be satisfied with clearing the patient's symptoms and finding a negative blood report. Every case in which a diagnosis of primary or secondary syphilis has been made, should have a careful neurological examination, mental status and spinal fluid determination before the patient is discharged as no longer in need of treatment. Every physician possesses the necessary knowledge to make such examinations. There is no need to mention the neurological methods; they are familiar to all physicians. Similarly, the mental status is not difficult to determine. It is important to seek indications of mental or personality changes; that is, to determine whether the patient has become irritable, antisocial, extravagant, demanding or forgetful. Convulsions may occur early in neurosyphilis. The wife, husband or someone close to the patient, if carefully questioned, can often tell of early personality changes. Grandiose ideas, as described in text-books, are not always an early symptom. These beliefs of great wealth or strength are often associated with more violent symptoms which necessitate treatment in a psychiatric hospital. With an early diagnosis of neurosyphilis, the physician is able to treat his patient in a general hospital or even in the patient's home.

In closing, I should like to point out that the treatment of neurosyphilis is highly satisfactory; that the earlier a diagnosis is made, the better may be the results effected from the treatment; that typhoid vaccine is a safe method for producting the required fever when given in divided doses; that the central nervous system may be invaded by the spirochete during the primary or secondary stage of the disease; that certain strains of the spirochete seem to have a predilection for the central nervous system; and lastly, that the physician in practice is able to treat satisfactorily early cases of neurosyphilis without the need of admission to a psychiatric hospital.

PUBLIC WARNED

Physicians should warn the public against the devices practiced and the false pretensions made by charlatans which may cause injury to health and loss of life.

From the Code of Ethics of the A. M. A.

SIMPLIFIED OFFICE PHOTOGRAPHY

Dr. F. Ronchese, Providence, R. I.

The dermatologist feels more than any other specialist the need for having good photographic records of his patients. The ordinary procedure of taking a photograph is long and tiresome for both the patient and the physician.

Often it is even embarrassing when the physician covers the role of a professional photographer. The apparatus commonly used for clinical photography is bulky, requires a lot of space, always difficult to find in the average office, and is expensive. To overcome technical and financial difficulties, Ronchese thought of using a flash synchronizer of the type used by newspaper camera men, mounted on a fairly good camera with double bellows extension for close ups.

Three previously fixed distances, sufficient for the need of routine photography, eliminate any further use of the ground glass and the long and tiresome procedure of focusing the subject. The camera is laid down on a table or on any flat mean of support at a previously fixed distance from the subject. The light is given by a small-sized photoflash bulb. The diaphragm is set at 1:16, the speed at 1/25th of a second. The distance measuring stick is withdrawn, the button which lights the bulb and at the same time opens the shutter is pressed, and the photograph is taken. Owing to the speed it becomes very easy to take a picture of a restless patient.

This procedure being quick, done by the physician himself, not very expensive (25c per photograph), and satisfactory, should make more popular routine office photography and increase considerably the percent of good medical illustrations.

Archives of Dermatology and Syphilology, 36:344, August, 1937.

INFRA-RED PHOTOGRAPHY IN THE DIAGNOSIS OF VASCULAR TUMORS

Dr. F. Ronchese, Providence, R. I.

Ronchese shows with many illustrations how infra-red photography helps in the diagnosis of vascular skin tumors when the presence of blood is doubtful.

American Journal of Surgery, 37:475, September, 1937



THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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OXYGEN THERAPY

In the last decade treatment by inhalation of oxygen has passed from the status of a futile gesture applied to the moribund patient for the comfort of a grieving family to that of a scientific rather exact therapeutic measure which at times may be life saving. Its greatest value as it is applied at present appears to be in the treatment of pneumonia and of certain cardiac conditions in which, as an accessory measure, it may carry the patient through a critical phase of his illness and make recovery possible. What is actually accomplished by the treatment is the overcoming of a state of anoxia or anoxaemia, a condition in which there is an actual deficiency of oxyhemoglobin in the circulating blood and which may result in damage to vital organs, especially the brain and the heart muscle. In coronary artery occlusion, the judicious use of oxygen has enabled many a patient to survive until the heart recovers from the initial shock. In the field of surgery oxygen is applied routinely over long periods to patients who have had lobectomy or thoracoplasty and is considered of great value.

A recent development, the use of 98% oxygen for the relief of abdominal distension such as occurs after operations and in many toxic cases of pneumonia, has now been made easily available by slight modifications of existing apparatus. This is also of use in collection of gas in certain other locations, notably in subcutaneous emphysema.

As is so often the case when a procedure is introduced which requires elaborate and expensive apparatus, the effective methods of giving oxygen have become much simpler and less expensive as time has gone on. At present oxygen therapy should be available in every well equipped hospital and the general practitioner should be able, when occasion demands it, to apply it in the home. The technique of application is simple and the methods of testing the amount of oxygen which the patient is receiving, a procedure which should always be used with any tent or box method, has been so simplified that it can be carried out routinely by the attending nurse.

If Thomas Beddoes, who founded the Pneumatic Institution at Clifton in 1798 could look down on what is now going on in the medical world, he would feel that again, as in the matter of anaesthesia inhalations, so now in case of oxygen therapy, his labors, the futility of which he once bewailed, had indeed borne fruit.

THE HOSPITAL AND THE COMMUNITY

"American Medicine, Expert Testimony out of Court" contains a great deal of wise and some less wise comment as to desirable and undesirable possibilities in the development of organized medical care. These comments and opinions cover a wide range of subjects, most of which are complicated and some of which cannot be settled at this time. The extracts from letters of physicians, which form the body of the report, are grouped under separate headings, so that one can look up any of the more important aspects of medical care. The medical periodicals have all published reviews of the work, two of the best of these being those in the issue of the *New England Medical Journal* of September 16, and the June number of the *Rhode Island Medical Journal*. Two sets of the original volumes are in the Rhode Island Medical Library.

Among the facts that emerge fairly clearly from all this discussion is this, that our hospital facilities are an essential factor in improved medical care for the great mass of the people. This is true in private practice and would be true in organized care of the indigent and near indigent. Any plans for care of the sick must recognize the importance of the hospital. Here and now, without necessarily any change in the method of financing medical care, it would seem possible to utilize our hospitals to greater advantage in this respect. The hospital could emphasize the consultant and diagnostic clinic function, making a point of returning the patient to his own physician in the shortest possible time.

The practitioner should be able to send his near indigent patient to the hospital, with confidence that the patient would be quickly returned to him with a complete report of the diagnostic methods employed and the conclusions. This would encourage physicians to use the hospital more for their poorer patients, would enable more of these patients to have the benefit of a thorough work up, and would enable the hospitals to use their facilities effectively. The consultation clinic which has been developed by the Providence Tuberculosis League and which is widely used by the doctors of Providence is a fine example of what can be done in this way.

This development of diagnostic work would not necessarily mean any great increase in the number of patients actually in the hospital at any one time. It would not mean at all that more patients should be taken out of private practice. Relatively few of the sick need a hospital work up and those that do, except for the truly indigent, can be returned promptly to their own doctor. Such a plan would undoubtedly strengthen the system of private practice. A pleasant and frequent contact with the hospital should form a very definite part in the life of every physician. The hospital is necessarily a center of medical study and knowledge. He should feel that this is to an extent his hospital, and a definite help to him in his practice.

Not the least important side of this question is the impending increase of government support and control of medical care. It will be most advantageous to all concerned if the integration of hospital care and private practice can be advanced further under the initiative of the medical men before the entrance of other forces into the field confuses the situation.

RHODE ISLAND MEDICAL SOCIETY

Meeting of the Council

A stated meeting of the Council of the Rhode Island Medical Society was held at the Medical Library Building, Thursday, September 16, 1937, at 4:00 P. M. The meeting was called to order by the President, Dr. Walter C. Rocheleau. Present were Drs. Rocheleau, Holt, Wells, Mowry, Jones, Miller, Christie. The minutes of the last meeting of the Council were read by the Secretary and were approved. It was voted that consideration of the budget for 1938 be deferred to the January meeting. The Secretary announced that he had received an application for fellowship by certificate from the New York State Medical Society to the Rhode Island Medical Society. He reported an inquiry from a physician practicing in Block Island as to fellowship in the Society.

Dr. Miller reported that, inasmuch as he had sent to the Committee on Publication his resignation as Editor of the *Rhode Island Medical Journal,* he could speak without personal bias on the condition of the *Journal.* He stated that in his opinion the present arrangement, whereby the Society contributes nothing to the support of the *Journal* but takes any profit that may accrue, is impracticable. He paid a well deserved tribute to Dr. Skelton for his efficient management of the *Journal* during many years. He recommended that the financial management of the *Journal* be vested either in the Publication Committee or the Business Manager. He stated four possible solutions of the problem:—

1. To discontinue publication of the transactions of the Society. After an unbroken record of 78 years this does not seem desirable. The Society would face increased lack of interest, the Library would lose the many exchanges and the books which are reviewed.

2. To arrange with the *New England Journal of Medicine* for publication of the transactions of the Society.

3. To return to the Business Manager control of the *Journal,* financial and otherwise.

4. To entrust financial and editorial control of the *Journal* to the Committee on Publication.

In case the last plan should be adopted, Dr. Miller recommended:—

1. That members of the editorial and business board of the *Journal* be not eligible for membership on the Committee on Publication.

2. That the Business Manager make a monthly report on the condition of the *Journal* to the Publication Committee.

3. That the Publication Committee submit to the Council an annual report on the financial condition of the *Journal*.

4. That the Council appropriate a sum equivalent to the price of one subscription to the *Journal* for each member of the Rhode Island Medical Society.

5. That the mailing list of the *Journal* include the names of each member of the Rhode Island Medical Society, each member of a District Society not a member of the State Society, publishers of journals received by the Medical Library in exchange for the *Rhode Island Medical Journal*, publishers of books received by the Medical Library from Review Editors of the *Journal*, libraries to which the Trustees of the Fiske Fund are accustomed to send copies of the Fiske Fund Essays.

6. That a combined mailing list for members of the Providence Medical Association and the *Journal* be considered.

These matters were discussed and were referred for judgment to the Committee on Publication. The meeting was adjourned at 5:00 P. M.

Respectfully submitted,

GUY W. WELLS, M.D.,
Secretary.

Meeting of the House of Delegates

The regular meeting of the House of Delegates of the Rhode Island Medical Society was called to order at 5 P. M. September 16, 1937, by the President, Dr. Walter C. Rocheleau.

The Secretary then read the report of the meeting of Council which had immediately preceded the meeting of the Delegates. It was moved, seconded and passed that the report be accepted.

Dr. Mowry then explained that changes in the number and the dates of the meetings of the Council and House of Delegates necessitated reporting the annual budget at the January meeting instead of the November, as had been the case in previous years. The House of Delegates approved the change by vote.

As there was no further business to come before the House of Delegates, the meeting adjourned.

Respectfully submitted,

GUY W. WELLS, M. D., *Secretary*

Report of Delegate to the American Medical Association

The Eighty-eighth Annual Session of the American Medical Association was held this year in Atlantic City. The total number of doctors registered was 9,764, almost 10,000.

Each year the size and significance of these meetings seem to increase. The Atlantic City Auditorium is the largest one in this country and its exhibiting space was taxed to capacity. Even the stage was utilized for exhibits. One could not, during the time of the convention, visit all exhibitions with profit though the program was arranged to conserve the members time to the greatest degree. Since the assembling hours of the various sections were staggered and the authors of most of the papers were also exhibitors, one found it comparatively easy to hear all of the papers of particular interest to himself, then to personally discuss the subject with the author in his booth. This plan, adopted last year, seems to have met with great favor. Never before have I seen such a constant shifting of audiences after each paper.

The Sessions of the House of Delegates began June 7 and lasted through June 10. There were several executive sessions.

After reading President Gordon Heyd's splendid address one gets an impression of the controversial subjects that are likely to arise. The fact that many such matters were discussed in a sound and unbiased manner is a great credit to the good judgment of the officers and members of the House of Delegates.

Dr. Heyd called attention to and warned the profession of the dangers of the extension of institutional medicine. Most of these institutions are faced with diminishing financial returns and are willing to accept government aid and later political domination. The possibilities from such institutions are alarming and will require alert, united medical opposition. Dr. Heyd also reviewed other problems which he believes can and should be solved by the profession.

President-elect Upham was chiefly interested in Medical Education and the influence the American Medical Association has exerted on the advancement of medical knowledge. He recommended to state societies consideration of plans whereby postgraduate work could be brought to the doctor. Some states already have in operation such courses. Dr. Upham also urged consideration of some plan to counteract the misinformation given to the public by quacks, cults and patent medicine venders.

The House of Delegates was honored by an address by the Honorable J. Hamilton Lewis of Illinois. Senator Lewis discussed a plan that is not quite clear to me, at least the details. The plan, as I understood it, embraced a scheme to issue Federal licenses to doctors and therefore subject them to governmental control in the matter of treatment of citizens of the State, the reason being that the Federal Government was naturally interested in the individual for economic, military and other reasons. Reduced to its simplest terms, such a plan means State Medicine. It should be emphasized that Senator Lewis apparently is not in sympathy with such a view and came both to warn the medical profession of the danger and to gain from the profession help in formulating a plan acceptable to them. Senator Lewis paid tribute to the service doctors had rendered to the public and also the exacting and expensive preparation incident to medical education. The proponents of the plan, of course, were not named. Senator Lewis further brought a message from the President who wished us success. The President expressed a hope that we might find a way to cooperate with him in a method that would be of service to the helpless and the afflicted within such province as the government might undertake.

Limited space prevents me from reporting more than a few of the interesting matters that came before the House.

At the Kansas City Session a resolution was adapted providing for the appointment of a committee to propose changes in the By-Laws Providing for Fitting Recognition to Fellows Rendering Distinguished Service in Science and Art of Medicine. This committee reported the necessary amendments to the By-Laws and the committee's report was adopted. Hence, it will now be possible for the American Medical Association to honor an outstanding member of the profession in some other manner than by election to an important office.

The Board of Trustees adopted a resolution recommending the establishment of a Council on Industrial Health to permit the Association to assist more efficiently in the prevention and treatment of an increasingly important phase of illness. The resolution was passed by the House of Delegates.

The House of Delegates approved the report recommending the international nomenclature for blood grouping as suggested by the Health Committee of the League of Nations as a standard for the profession. Also, that laws modeled after those of New York and Wisconsin be passed permitting courts to order blood grouping tests in cases of disputed paternity and to receive the results in evidence.

The following officers were elected:

President-Elect, Dr. Irvin Abell; Vice-President, Dr. Junius B. Harris; Secretary, Dr. Olin West; Treasurer, Dr. Herman L. Kretschmer; Speaker of the House of Delegates, Dr. N. B. Van Etten; Vice Speaker of the House of Delegates, Dr. H. H. Shoulders; Trustees, Dr. Arthur W. Booth, Dr. R. L. Sensenich.

San Francisco was chosen for the next Annual Meeting.

Respectfully submitted,

GUY W. WELLS, M.D.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the October Meeting

The regular monthly meeting of the Providence Medical Association was held at the Medical Library, Monday, October 4, 1937, at 8:30 P. M. In the absence of the President, the meeting was called to order by Dr. Alex. M. Burgess. The Secretary read the minutes of the June meeting, which were approved as read. The Secretary read the report of the Standing Committee, approving the applications for membership of the following:

Henry M. Bernhardt
William Fain
Robert Fienberg
Frank Domenic Fratantuono
David Freedman
John E. Menzies
Edwin Basil O'Reilly
John Francis Regan
Vincent Paul Rossignoli
Charles Edwin White

On motion of Dr. Gormly, this report was accepted and the applicants were declared elected as members of the Association.

Dr. DeWolf read the final report of the Committee on Medical Care of the Low Income Group. On motion of Dr. Hughes, amended on motion of Dr. Chafee, this report was accepted and placed on file, the Committee was given a vote of thanks for their work, and the Secretary was instructed to send

a copy of the report to each Rhode Island Senator and Representative in Washington. On Dr. DeWolf's inquiry as to whether the Committee was discharged, the acting President ruled that the Committee was discharged as recommended in its report. Dr. Ruggles then spoke on the importance of the work of this Committee and recommended that the Association continue its interest in medical care of the low income group.

Dr. Streker read the final report of the Committee on Reorganization. On motion of Dr. Gormly, it was voted to accept the report, to refer it to the Standing Committee, and to send a copy to each member of the Association before the next regular meeting. The report was discussed by Drs. Ruggles, Gormly and Streker.

Dr. Seebert J. Goldowski then presented a paper on "Peripheral Arterial Disease." The paper was illustrated with lantern slides.

Dr. William Newton Hughes read "Two Well Known Poems of Neurological Interest." The poems were Kipling's "The Post that Fitted" and "La Nuit Belle." The first illustrates epilepsy and the second, alcoholism.

Dr. Charles Bradley then presented a paper entitled "The General Practitioner and the Feeble-Minded Child." This paper was discussed by Dr. Langdon.

The meeting was then adjourned. Attendance, 94. A collation was served.

Respectfully submitted.

HERMAN A. LAWSON, M.D.,
Secretary.

Final Report of the Committee on Medical Care of the Low Income Group

The Committee on Medical Care of the Low Income Group, Doctors DeWolf, Beardsley, Belliotti, Nestor, Richardson, W. S. Streker, Wells, Jordan, Buffum, and Saklad, appointed on November 4th, 1935, by Dr. William P. Buffum, then President of this Association, offers as its final Report the following:

The investigation proposed for study by this Committee was twofold in nature: First, to determine if, in Providence, any considerable proportion of persons in the Low Income Group suffered hardship through the payment of medical fees. Second, if so, and as a result, was there, in this group, lack of adequate medical care.

As a natural corollary to these problems, should they be answered in the affirmative; ought the Providence Medical Association to take action to relieve the conditions. Two questions immediately presented themselves: First, how define the Low Income Group. Second, how undertake the investigation? The first question, after much discussion and reference to literature upon the subject, was answered thus:

Annual Income, from all sources, below $900 for a family of four persons, was considered too little to warrant paying *any* fees; such families were listed as Clinic cases. Most families, even if large, with income of $1700 or over, were rated as able to pay regular fees. The Low Income Group was classified as follows:

4 in the family $900
to
5 in the family $1100
to
6 in the family $1300
to
7 in the family $1500

The second question, the method of investigation, after discarding several suggested plans, was decided as follows:

Through the co-operation of the Personnel Director or Industrial Nurse in five of our largest local industries, intimate personal questioning was carried out with those of their employees falling in the Low Income Group. The questions asked were based upon a comprehensive questionnaire, prepared by the Committee, in consultation with Professor Carl Doering of Harvard University.

The industrial concerns chosen were: Gorham Manufacturing Co., Brown & Sharpe, Nicholson File, Wanskuck Co., and the U. S. Finishing Co. The interest shown by the executives of these companies was great; the labor of the investigation, undertaken by the Personnel Director and Nurses, was time consuming and, no doubt, exhausting. The Committee here would express to all these individuals its most sincere appreciation and thanks. It was believed and proved to be the fact, that such close, intimate, and friendly contact between employee and intelligent investigator would yield the most accurate and worthwhile records obtainable. This method is conceded by those familiar with such investigations to be the most accurate yet devised. Though the total figures might not be large, your Committee believed they would represent a fairly accurate cross section of like industrial

employees throughout the City. This then was the set up. The results:

1500 employees were interviewed or their incomes investigated.

84 employees fell within the above classification of Low Income Group.

54 of the cases were considered "satisfactory," i.e. to have been well cared for in sickness for which they paid medical fees without undue hardship.

17 cases had no sickness during 1934-35, the years covered by the questionnaire.

2 did not receive proper care, probably through their own neglect.

2 used the free clinic too much, and should have employed a doctor.

3 paid too little or not at all.

6 paid too much, two of these being doubtful cases, in which all the circumstances could not be known.

Several interesting facts were developed as the answers to the questionnaires were studied.

First, Average charge for Home Visits $2.53
Average charge for Office Visits $1.90

Your Committee was impressed by the moderate charges to these people of the Low Income Group. It was evident that the time immemorial habit of the medical profession in adjusting medical charges to the patients' ability to pay was almost universally followed in these cases. In two instances there would appear to be overcharging, but in these all the circumstances were not known.

Second, in several cases, what has been called "Catastrophic Illness" occurred, as for instance, sickness, confinement, and operation in one year. Almost without exception, in these cases, payment was made, up to the family's ability, and then recourse was had to the clinic or hospital for free treatment.

Conclusion: It is recognized by your Committee that the number of cases in this group is small, but as stated above, it is probably accurate and represents fairly well a cross section of the Low Income Group in Providence. It is felt that could an equally correct, but much broader study be made, which would take time and money, the results would, no doubt, be better. Such a plan is, at present, vaguely outlined by one of our Social Agencies and should it materialize, will be reported to this Association.

It is clearly recognized by your Committee that its investigation is in no wise a solution of the ever present problem of the cost of medical care to the Low Income Group and that all further efforts to solve this problem should receive our earnest support.

Finally, in view of the findings, as outlined above, i.e., 1,500 cases considered, 84 falling within the Low Income Group, 6 having paid too much for medical care, and further, in the belief that with the fine equipment of this City in the way of Hospitals, City and District Nurses, free Clinics, etc., the great majority of those in the Low Income Group are adequately cared for without undue financial strain to themselves, and again, being confident that no formal plan or action on the part of this Association can actually bring relief to those few who may be sufferers from the expense of sickness.

Your Committee recommends that no such action be taken.

The Committee also asks that it now be discharged.

Respectfully,
HALSEY DEWOLF, M.D.,
Chairman.

Report of the Committee on Reorganization

Oct. 4, 1937.

To the members of the Providence Medical Association:

At the January meeting of this year it was suggested to the Providence Medical Association that this society should take a more active part in the development and control of medical practice in the community, including the various health agencies, clinics, industrial medicine, and medical legislation; also that it should exercise a greater influence in attempts to solve present day medico-economic problems. It was further suggested that some changes in our organization be considered in order to carry out the above, and this committee was appointed to study the question.

Having arrived at definite conclusions, the committee submitted a preliminary report at the June meeting. This was done in order to give the members ample opportunity for personal deliberation. This report stated that the committee had decided to make two specific recommendations:

I. That the Standing Committee be enlarged to afford more complete representation in this committee which initiates practically all of the business of the association and also acts as the nominating committee.

II. That the association employ an executive secretary. This proposal is in keeping with present day trends in many progressive county and state medical societies. Considerable correspondence has been held regarding this question, with the A.M.A. and several county medical societies who employ executive secretaries. A recent exhaustive study was furnished by the A.M.A. Opinions and comments were overwhelmingly favorable to the idea of employment of an executive secretary.

An executive secretary would work with and under the direction of the Standing Committee, act as secretary to the various other committees, thereby correlating all of the society's activities. The indications are that under this plan the activities of the society would increase and become more efficient and effective. The association would keep in touch with the various health agencies which have progressed to wide development with little or no organized medical supervision or direction. Medico-economic problems and matters concerning public relations require more executive activity than the elective officers can be expected to perform. It is felt that these and other related services would increase considerably the value of this society to its members.

We therefore, in this the final report of the committee, recommend the following changes in the by-laws:

Article I. Sec. 1. That the words "consisting of five members" be deleted.

Article I. Sec. 6: That the first paragraph be changed to read as follows: The Standing Committee shall consist of the President, Vice-President, Secretary, and Treasurer, *ex-officio*, and of ten members, and after the adoption of this amendment the present membership shall be added to as follows:

two members shall be elected for a term of five years,
one member for a term of four years,
one member for a term of three years,
one member for a term of two years,
one member for a term of one year,

and thereafter two members each year for a term of five years.

Article I. Sec. 6. Be amended to read at the end of paragraph three: The Standing Committee shall be authorized to employ an executive secretary, to outline his duties and to fix his salary and expenses of office within the appropriation voted by the association for the purpose.

Respectfully submitted,

Wm. S. Streker, M.D., *Chairman*
Peter P. Chase, M.D.
Frank B. Cutts, M.D.
Wm. P. Buffum, M.D.
Harry C. Messinger, M.D.
Wm. A. Horan, M.D.
Frederic J. Burns, M. D.
Executive Secretary to the Committee

Rhode Island Hospital

SCHEDULE FOR NOVEMBER, 1937

Thursday, November 4
Gyn. Staff Meeting ..... 8.30 P. M.
Friday, November 5
G. U. Staff Meeting ..... 7.30 P. M.
Surgical Staff Meeting ..... 8.30 P. M.
Wednesday, November 10
Annual Meeting ..... 12.00 noon
Tuesdays, November 9 and 23
Clinical-Pathologic Conference ..... 12.00 noon
Mondays
Surgical Grand Rounds ..... 10.00 A. M.
I. November 8 and 22
II. November 1, 15 and 29
Thoracic Clinic ..... 4.30 P. M.
Tuesdays
Gastro-Intestinal Clinic ..... 9.30 A. M.
Surgical Grand Rounds ..... 10.00 A. M.
I. November 1, 15 and 29
II. November 9 and 23
Wednesdays
Tumor Clinic ..... 10.00 A. M.
Skin Clinic ..... 12.00 noon
Thursdays
Orthopedic Grand Rounds ..... 9.00 A. M.
Thoracic Clinic ..... 11.30 A. M.
November 11—Armistice Day
Fridays
Fracture Grand Rounds ..... 11.00 A. M.
Heart Conference ..... 11.30 A. M.
Saturdays
Neurological Grand Rounds ..... 9.00 A. M.
Medical Conference ..... 10.00 A. M.

On October 1st, Dr. Daniel M. Swan, of Watertown, N. Y., left for his home, having served as Intern at the Rhode Island Hospital for two years. Dr. Swan is a graduate of Colgate University and

the University of Rochester Medical School. Dr. Swan contemplates entering Peter Bent Brigham Hospital on January 1, 1938, having received a year's appointment in Medicine in that institution.

Dr. Ralph Richardson, who substituted in an administrative capacity during the past Summer, on October 1st entered the Memorial Hospital in Boston, having accepted a Pathological internship for a year.

Dr. David P. Dutton, a graduate of Harvard University Medical School in 1937, started his internship on October 15th. Dr. Dutton's home is in Wakefield, Mass.

Dr. Charles Chesner started a Pathological internship on October 15th.

Woonsocket Hospital

The regular meeting of the Woonsocket Hospital Staff was held September 13, 1937, with Dr. T. Frank Kennedy presiding. Dr. Thomas J. Lalor was the main speaker of the day. He read a paper entitled "Arthritis, Atrophic and Hypertrophic." This was very well received and was followed by considerable discussion in which several of the members participated.

On September 27, the Monthly Clinical Conference was held. The Medical Records Committee offered a report stressing the importance of complete records. A general discussion followed. During the latter half of the period, Dr. Rocheleau presented a case of "Petit Mal".

At a recent meeting of the Board of Trustees of the Woonsocket Hospital, Dr. Walter C. Rocheleau, President of the Rhode Island Medical Society, was elected a member of this Board.

NEW ENGLAND SURGICAL SOCIETY

The meeting of the New England Surgical Society was held in Providence, October 1 and 2, with headquarters at the Biltmore Hotel. Attendance was over 100. Friday, October 1, operative clinics were held from 8:00 to 10:00 A. M.; at the Rhode Island Hospital by Drs. Kingman, J. C. O'Connell, Stone, Waterman, Pitts, McCabe, Messinger, C. O. Cooke and Kerney; at the Memorial Hospital by Drs. Hussey, Holt and Shaw. At the Peters House Auditorium of the Rhode Island Hospital, the following demonstrations were given:

The Surgical Treatment of Hare-Lip and Cleft Palate by Dr. Albert A. Barrows

Presentation of Thoracic Clinic Patients by Dr. Halsey DeWolf and associates

Presentation of a Group of Tumor Clinic Patients by Dr. B. Earl Clarke and associates

Presentation of Fracture and Orthopedic Patients by Drs. Murray S. Danforth, Peter P. Chase, Herbert E. Harris, and Henry F. McCusker

The Use of 95% Oxygen in the Treatment of Abdominal Distension by Dr. Alex. M. Burgess

Posture in Anesthesia by Dr. Albert H. Miller

Summary of End Results in the Treatment of Carcinoma of the Cervix by Dr. George W. Waterman

At the Memorial Hospital the following demonstrations were given:—

Internal Fixation of Hip Fractures by Dr. Herbert E. Harris

Surgical Risks from the Medical Standpoint by Dr. John F. Kenney

Surgical Risks from the Standpoint of the Anesthetist by Dr. Meyer Saklad

X-Ray Aids in Surgery by Dr. Emanuel W. Benjamin

Two Problem Cases: 1. Acute Obstruction Due to Cancer of Sigmoid and Transverse Colon — Operation—Complications. 2. Congenital Retrovaginal Fistula in a Child 7 years of age—Operation by Dr. Arthur T. Jones

Case Report: Pyloric Stenosis, primary Ramstedt operation, secondary posterior gastro-enterostomy. Motion pictures of Common Duct Stone. Slides showing Injection of Common Duct by Dr. Frederic V. Hussey

Case Reports: Operation and After-Treatment of Thoracoplasties by Dr. Eliot A. Shaw

Case Reports: 1. Abdominal Pregnancy. 2. Compound Fracture of the Skull caused by bursting emery wheel by Dr. Charles H. Holt.

At 1:00 P. M. luncheon was served at the Rhode Island Hospital.

Friday afternoon the following scientific program was presented at the Nurses' Auditorium of the Rhode Island Hospital:—

A Series of Atypical Osteotomies for Deformity by Dr. Frederic J. Cotton. *Discussion:* Dr. Ezra A. Jones, Dr. Frank R. Ober

Sub-periosteal Resection of the Manubrium for Funnel Chest by Dr. Philemon E. Truesdale. *Discussion:* Dr. James W. Sever, Dr. Frederic J. Cotton

Immediate Surgery in Acute Cholecystitis by Dr.

Howard M. Clute. *Discussion:* Dr. Carl M. Robinson, Dr. Frank H. Lahey

Acute Haemorrhagic Pancreatitis by Dr. George Dunlop—by invitation. *Discussion:* Dr. Ernest L. Hunt, Dr. Irving Walker, Dr. Lium

The Surgical Treatment of Abdominal Fistulae by Dr. Samuel F. Marshall—by invitation. *Discussion:* Dr. Frank H. Lahey, Dr. H. Gildersleeve Jarvis

Intestinal Tuberculosis by Dr. George A. Moore *Discussion:* Dr. James W. Jameson

At 5:00 P. M. the meeting adjourned to the Squantum Club where a Rhode Island Clam-bake was served.

Saturday morning, the following program was presented at the Rhode Island Medical Library Auditorium:—

The Operative Treatment of Ulcerative Colitis by Dr. Charles C. Lund. *Discussion:* Dr. Richard B. Cattell, Dr. Leland S. McKittrick

Carcinoma of the Colon by Dr. Donald S. Adams. *Discussion:* Dr. Edward L. Young, Jr., Dr. Charles L. Larkin, Dr. Arthur W. Allen, Dr. Frank H. Lahey

The Relief of Pain in Malignant Disease by Dr. John S. Hodgson. *Discussion:* Dr. Ernest M. Daland, Dr. James C. White

An Unusual Case of Intestinal Obstruction by Dr. Daniel C. Patterson. *Discussion:* Dr. Robert C. Cochrane, Dr. Donald B. Wells

Reconstruction Operations for Hypertrophy of the Female Breast by Dr. Horace K. Sowles. *Discussion:* Dr. George C. Wilkins, Dr. Frank A. Pemberton

At the executive session, the following were elected members of the Society:—

Edward H. Kirschbaum	Waterbury, Conn.
George F. Dwinell	Manchester, N. H.
Peter P. Chase	Providence, R. I.
George W. Waterman	Providence, R. I.
Philip H. Wheeler	Brattleboro, Vt.
Herbert A. Durfee	Burlington, Vt.
Charles H. Jameson	Camden, Maine
Stephen A. Cobb	Sanford, Maine
George A. Tibbetts	Portland, Maine
Gilbert Horrax	Brookline, Mass.
Harlan F. Newton	Brookline, Mass.
Grantley W. Taylor	Boston, Mass.
Bancroft C. Wheeler	Worcester, Mass.
Marius N. Smith-Petersen	Newton, Mass.
Fletcher H. Colby	Boston, Mass.
John Rock	Brookline, Mass.
Horatio Rogers	Newton Centre, Mass.
Charles L. Curtis	Salem, Mass.
Carl H. Stevens	Belfast, Maine

Dr. John M. Birnie, of Springfield, was elected President and Dr. John F. Gile, of Hanover, Secretary.

The ladies who attended were entertained on Friday morning by Mrs. Murray H. Danforth with a tour of inspection of the new Rhode Island School of Design and the Carrington mansion, followed by a luncheon at the Rhode Island Country Club. In the afternoon they took the ten-mile drive in Newport. They were entertained at dinner by Mrs. Herman C. Pitts and Miss C. Amey Kingman.

PERSONAL NOTES

October 13.

At the meeting of St. Joseph's Hospital Staff Association, held at the Nurses' Auditorium at 8:45 P. M., Dr. Charles A. McDonald spoke on "Brain Pathology with Clinical Histories." Collation was served.

Drs. William B. Cohen, F. Ronchese, and Vincent J. Ryan attended the first quarterly meeting of the New England Dermatological Society, held at the New Haven Hospital.

October 15.

Initiating the fiftieth season of the activity of the Friday Night Medical Club of Providence, Dr. Dennet L. Richardson read a paper on "Prontylin." He reported the results of treatment with sulfanilamide at the Charles V. Chapin Hospital in 155 cases of streptococcus infection. The paper was discussed by Dr. Kalei K. Gregory, Dr. Edmund G. E. Anderson, and members of the Club.

October 19.

The regular monthly meeting of the General Staff of the Homeopathic Hospital of Rhode Island was held at the hospital at 12:30 P. M. Dr. W. Richard Ohler of Boston spoke on "Certain Aspects of the Relationship of Vitamin Deficiency to General Practice."

The Annual Meeting and Dinner of the Rhode Island Record Librarians' Association was held at the Narragansett Hotel on Tuesday evening, October 19, 1937, at five o'clock.

Following the dinner, the regular business meeting of the Association was called to order by Miss M. Irene Cavanaugh, President. Officers for the coming year were elected: Miss Elizabeth M. Bingham, President; Miss Sarah Litwin, Vice President, and Miss Mary Nunez, Secretary-Treasurer.

Mrs. Ellison Creighton Frazier, Record Librarian of the Rhode Island Hospital, who has retired, was presented with a farewell gift from the members of the Association.

After a round table discussion, the meeting was adjourned at 8:00 P. M.

October 22

At the meeting of the Providence Medical History Club, Dr. John E. Donley read a paper on "Benjamin Rush."

October 26

The Amos Throop Medical Club was entertained by Dr. George L. Shattuck. Dr. Walter C. H. Weigner read a paper on "Functional Factors in Disease."

Drs. Eliot A. Shaw and Charles J. Ashworth returned from a two weeks visit to surgical clinics at St. Louis and the Mayo Clinic at Rochester.

October 28

At the Regular Quarterly Meeting of the Rhode Island Medico-Legal Society, held at the Medical Library at 5:00 P. M., Dr. James Philip Deery, Chief of the Division of Industrial Hygiene, Rhode Island Department of Public Health, read a paper on "Industrial Hygiene and its Effect on Compensation."

RHODE ISLAND MEDICAL SOCIETY

The Library Committee gratefully acknowledges a gift to the Davenport Collection from Dr. G. Alder Blumer:—"Exercitationes de Generatione Animalium." By William Harvey, Amsterdam, 1651.

RECENT BOOKS

Surgical Pathology of the Thyroid Gland. By Arthur E. Hertzler, M.D., pp. 298 with 238 illustrations. Cloth, $5.00. J. B. Lippincott Company, Philadelphia, 1936.

This is a most interesting book on thyroid disease, probably more suited for those who are especially interested in this subject. It is not written in the manner of the usual text-book but as the author states, an attempt to record his observation of the disease based upon a long clinical experience. He stresses our lack of knowledge relative to the histology and physiology of the gland and the need for further study of the problem. On many points he does not appear to be in accord with the prevailing views upon the subject. He believes that the so-called non-toxic goitre and degenerative goitres are productive of cardiac changes leading to failure and holds that their removal is as important as the removal of the hyperplastic types that produce obvious clinical signs. Recognition and treatment of fetal adenoma of the thyroid by removal is urgently advised because of the high percentage of malignancies originating in these congenital tumors. His explanation of "benign metastasizing' goitre is that the malignant ademona is overlooked among surrounding adenomatous formation. The book is recommended to those interested in this subject.

James H. Fagan, M.D.

Emotional Adjustment in Marriage. By Le Mon Clark, M.S., M.D., Assistant in Obstetrics and Gynecology, University of Illinois College of Medicine. pp. 261, Cloth, $3.00, The C. V. Mosby Co., St. Louis, 1937.

Under this title, Dr. Clark presents a dignified, scientific discussion of the topics comprised in the popular mind under the heading "Sex." The work is addressed to normal young people of the marrying age; it considers no sexual abnormality. To those who hold that sexual matters should be left to the teaching of harsh experience, the author replies: "By veiled suggestion, by innuendo, by downright falsehood and misrepresentation, by anything and everything but by 'leaving them to nature' we have completely altered this otherwise natural response." Unequivocally condemning induced abortion, he deals reasonably with the problem of birth control, showing by arithmetical calculation that some natural or artificial form of birth control must sooner or later supervene to prevent hopeless overcrowding.

This book is to be recommended to the married and those who contemplate marriage and to parents, physicians and teachers who through ignorance or diffidence are unable to give the instruction on sexual matters which the present enlightened state of civilization demands.

An Introduction to Dermatology. By Richard L. Sutton, M.D., Sc.D., LL.D., F.R.S. (Edin) and Richard L. Sutton, Jr., A.M., M.D., L.R.C.P. (Edin). Third Edition, pp. 666, with many illustrations. Cloth, $5.00. The C. V Mosby Company, St. Louis, 1937.

This book is not merely a compilation of the work of others as the authors do not hesitate to express their own opinions. Special emphasis is laid on the importance of accertaining the cause, if possible, before instituting treatment, and reliance on purely symptomatic measures is confined to diseases of obscure or unknown etiology.

To facilitate the diagnosis of tuberculous lesions, the authors have used a modification of the classification of Gans. Considerable attention is given to the parasitic affections. Over 100 pages containing many beautiful photographs are devoted to plant and animal parasites capable of producing disease in man. It is particularly interesting to note the emphasis placed on bismuth in the treatment of latent syphilis. Although the book is intended primarily for students, I feel certain it will meet with the approval of all practitioners of medicine.

Vincent J. Ryan, M.D.

THE LABORATORY DIAGNOSIS OF SYPHILIS, THE THEORY, TECHNIC, AND CLINICAL INTERPRETATION OF THE WASSERMANN AND FLOCCULATION TESTS WITH SERUM AND SPINAL FLUID. By Harry Eagle, M.D., with Foreword by J. Earle Moore, M.D., pp. 440, with 27 illustrations. Cloth, $5.00. The C. V. Mosby Company, St. Louis, 1937.

This timely book discusses the laboratory diagnosis of syphilis in a comprehensive and readable way. The time honored Wassermann test and the newer flocculation tests are critically reviewed. The larger portion of the book is perhaps mostly of interest to physicians and technicians actually engaged in the laboratory diagnosis of syphilis. Details of technic, sources of error and how to avoid them, relative merits of various technics and the standardization of technics are all clearly and helpfully discussed.

The section on "The Clinical Evaluation of the Serologic Report", should be of more general interest. The twenty pages devoted to theories of the nature of the reactions may seem abstract to some but the following chapters, and particularly that on the interpretation of doubtful reports, should be helpful to all clinicians. In this connection he deplores the common practice of reporting 1+, 2+, 3+ and 4+ and makes a plea for making all reports either negative, positive or doubtful. This should meet with universal approval.

This book should be in the working library of every clinical laboratory.

B. EARL CLARKE, M.D.

YOUR DIET AND YOUR HEALTH. By Morris Fishbein, M.D. Cloth, pp. 298, $2.50, McGraw-Hill Book Company, Inc., New York, 1937.

Mindful of the confusion that is prevalent among the laity regarding diet and nutrition, the author attempts to clear the minds of those who are anxious to learn the truth. The subject has suffered considerable abuse from charlatans, quacks, and food faddists. "Your Diet and Your Health" is therefore timely. This monograph is divided into 26 chapters and an appendix which consists of a considerable number of tables showing the carbohydrate, protein and fat contents of the various foods and their caloric value. The opening chapter deals with discussion of the calorie, what is meant by the term calorie and the variation in caloric needs of different individuals. This is followed by a brief but quite adequate resumé of the physiology of digestion and its relation to good health.

In the chapters that follow he humorously and in spots quiet severely criticizes the various diet systems, and backed by scientific evidence, tells us how absurd and unscientific their claims are. The much talked of and quite frequently abused vitamins are also taken up step by step, their real importance explained and source of supply in nature indicated. There are special chapters on diets in disease conditions, on food sensitivities and other special diets. The material is well organized, vigorously and smoothly written and easily digestible.

LOUIS I. KRAMER, M.D.

SYPHILIS, THE NEXT GREAT PLAGUE TO GO. By Morris Fishbein, M.D., Editor, Journal of the American Medical Association and of Hygeia, the Health Magazine. Cloth, $1.00, David McKay Co., Philadelphia, 1937.

In this handbook of seventy pages, with many graphic charts and well chosen illustrations, Dr. Fishbein describes in simple terms this great plague, its reason for being and the measures to be taken for its eradication. For this scourge can be eradicated and it will be if the knowledge contained in this book is thoroughly broadcast and absorbed. This is a text which can contribute tremendously to human welfare and happiness. Because the subject is one which may any day become of personal interest to each of us, the heading on the jacket of the book is well justified: "A Handbook for Every One."

SENILE CATARACT, METHODS OF OPERATING. Third Revised Edition. By W. A. Fisher, M.D., F.A.C.S., pp. 150 with 181 illustrations. Cloth, .. The H. G. Adair Printing Company, Chicago, 1937.

The first chapter in this book was written by the late Ernst Fuchs and describes the operation for removal of the lens as he did it, a method which has become practically the standard in this country. There are chapters by Barraquer, Van Lint and Holland of India describing the Col. Smith or Indian intracapsular method very exactly. The preparation of the patient and minute details of operative technique and after-care are thoroughly covered. There is good meaty material in every chapter. The illustrations are for the most part simple diagrams which thoroughly illumine the text. Every oculist should own this book and read it.

HARRY C. MESSINGER, M.D.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACTS OF CONGRESS OF AUGUST 24, 1912, AND MARCH 3, 1933 of RHODE ISLAND MEDICAL JOURNAL published MONTHLY at Providence, Rhode Island for OCTOBER, 1937

State of RHODE ISLAND
County of PROVIDENCE

Before me, a NOTARY PUBLIC in and for the State and county aforesaid, personally appeared CREIGHTON W. SKELTON, M.D., who, having been duly sworn according to law, deposes and says that he is the BUSINESS MANAGER of the RHODE ISLAND MEDICAL JOURNAL and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management, etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, to wit:

1. That the names and addresses of the publisher, editor, and business manager are: Publisher, RHODE ISLAND MEDICAL SOCIETY, 106 FRANCIS ST.; Editor, ALBERT H. MILLER, M.D., 28 Everett Ave.; Business Manager, CREIGHTON W. SKELTON, M.D., 106 FRANCIS ST.; all of Providence, R. I.

2. That the owner is THE RHODE ISLAND MEDICAL SOCIETY.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are none.

CREIGHTON W. SKELTON, M.D.

Sworn to and subscribed before me this first day of October, 1937.

THOMAS RUSH, Notary Public
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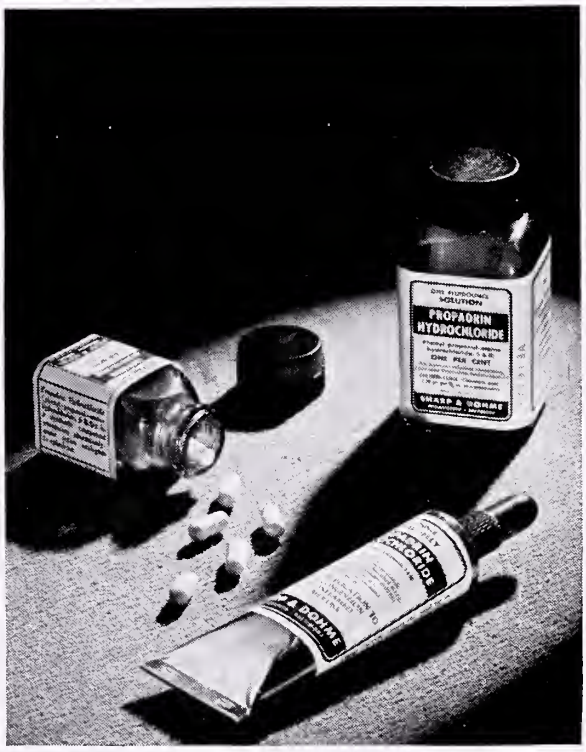
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Peripheral Arterial Disease. By Dr. Seebert J. Goldowsky

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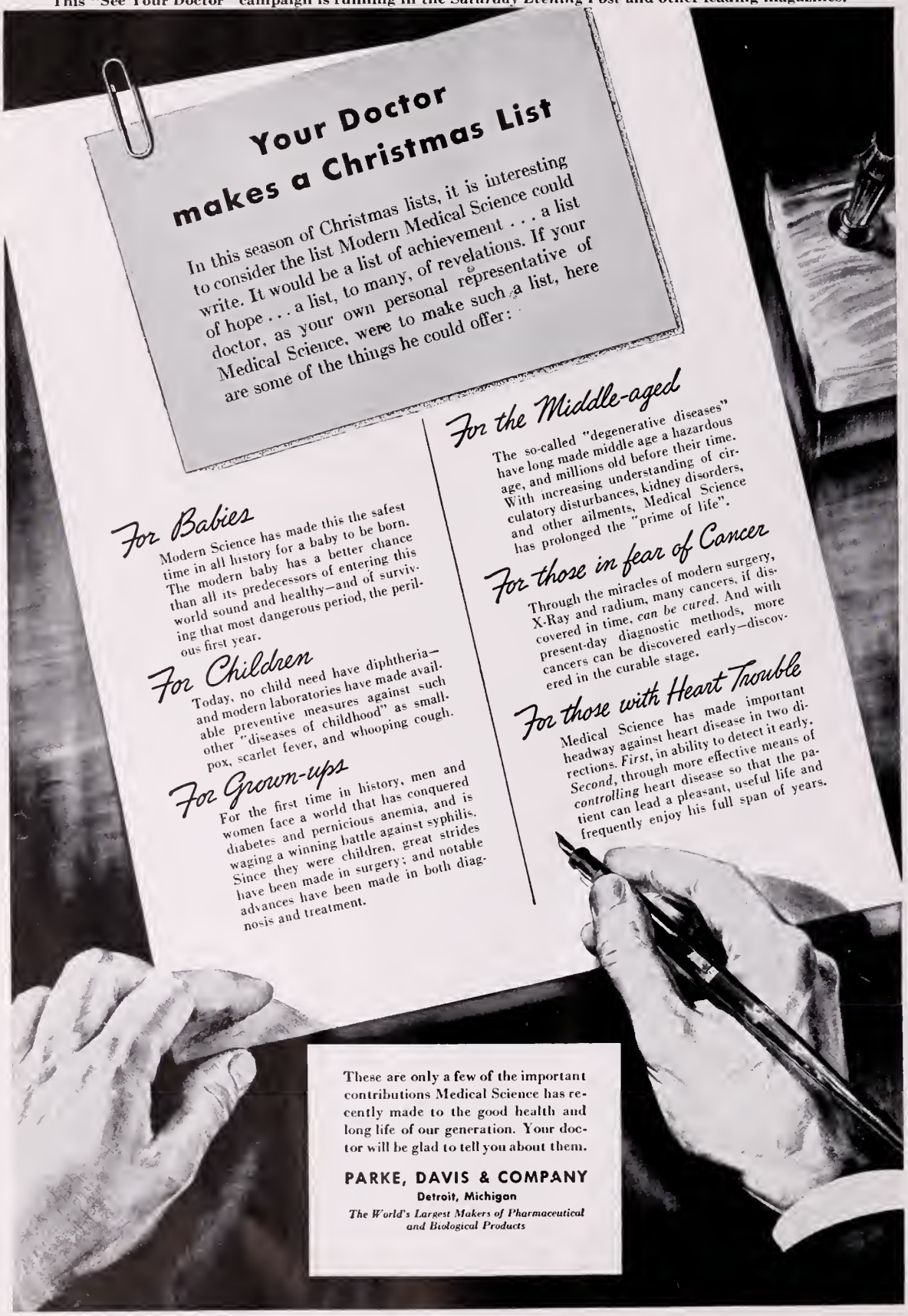
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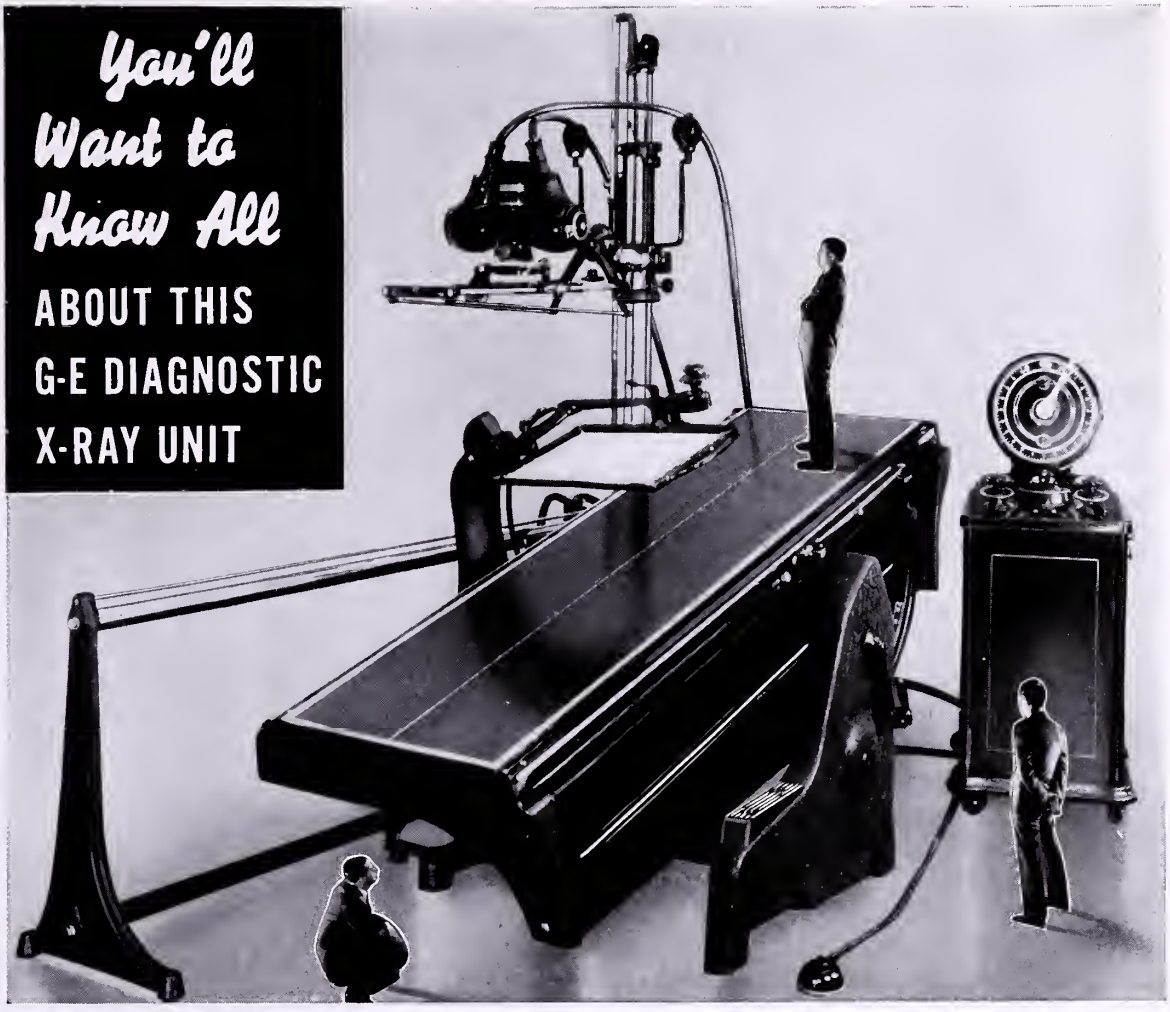
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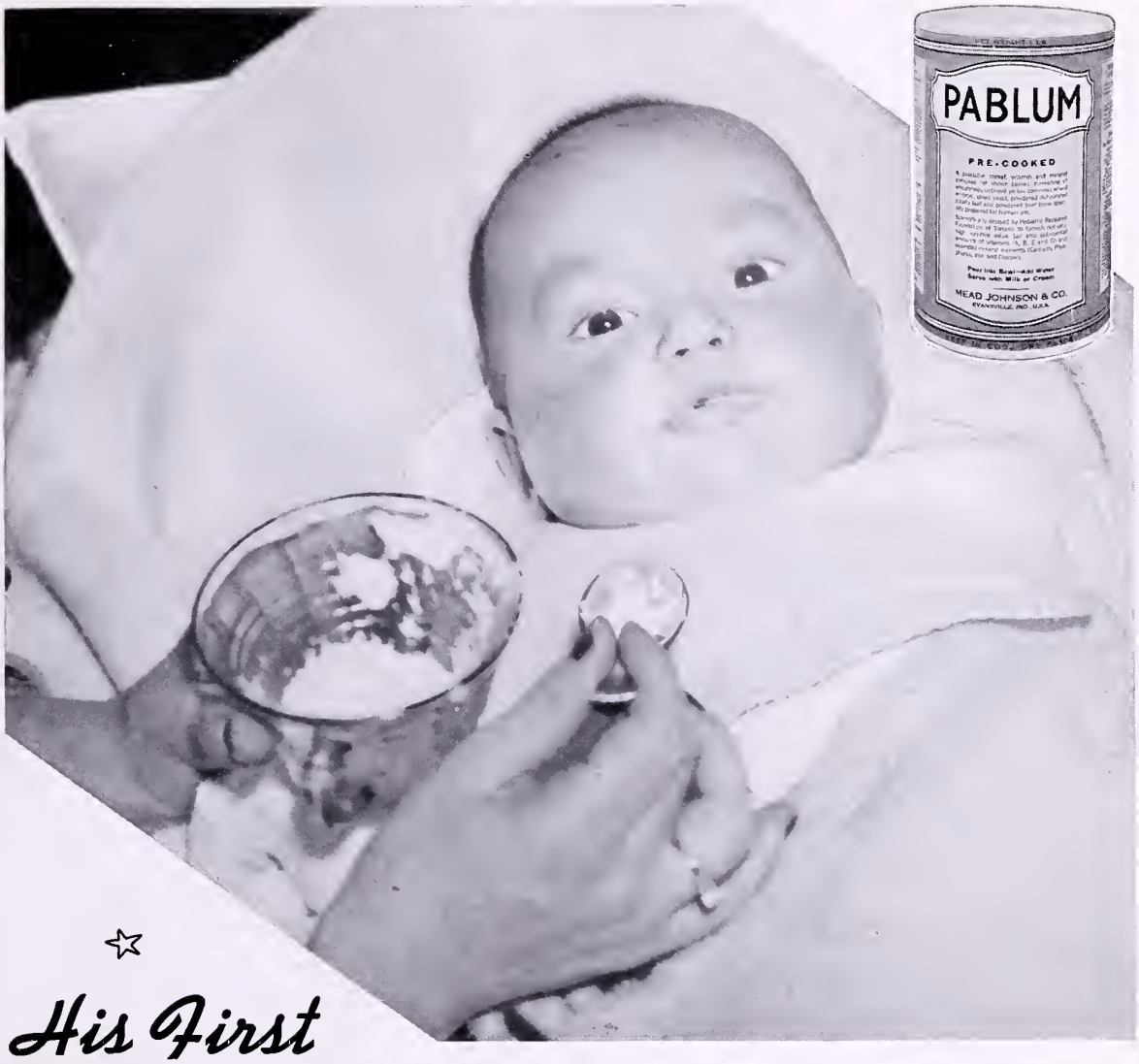
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VOLUME XX
NUMBER 12 | Whole No. 339 | DECEMBER, 1937 | PER YEAR $2.00 SINGLE COPY 25 CENTS

THE FAMILY PHYSICIAN AND THE FEEBLEMINDED CHILD

CHARLES BRADLEY, M.D.
EAST PROVIDENCE, RHODE ISLAND

Gradually coming to the realization that their child is mentally defective is without doubt one of the most tragic experiences through which any young couple may have to pass. Driven to silence by the popular fancy that feeblemindedness is a family disgrace, to be discussed only in whispers, and overwhelmed by the belief that their youngster is doomed to an unproductive and unhappy life of ridicule, the young parents invariably first of all turn to their family physician for his verdict and his advice. They find him interested, sympathetic, anxious to help, but, is he proficient in clearly explaining their child's condition to them and constructively helping them to plan treatment, training, and education? That question each of us can answer only in the light of his own experience.

The fact that the family physician is so widely and hopefully sought as the first source of advice would immediately force the problem into the field of medicine, even if feeblemindedness itself were not by its nature so personal and individual a human handicap that only the physician should be entrusted with its care. The common legal practice of requesting medical opinion as to the intellectual capacity of defective children further makes it imperative that every physician familiarize himself at least with the clinical aspects of mental deficiency. Unfortunately, even at the present time opportunities for training and experience in this field are practically nonexistent for the average medical man during his medical school and hospital years. A constructive step might be more frequent discussions of this and allied problems in medical society meetings.

Nature of the Problem

The nature of feeblemindedness might be more comprehensible and therefore more interesting to most physicians, if its definition were not clouded by that "certain vagueness" unfortunately so often associated with mental disorders. Even our most lucid philosophers and psychologists have not so far supplied us with a universally acceptable definition of intelligence. Since the practicing physician can afford little time for academic quibbling, one of a number of practical working definitions may suffice his needs. From this standpoint we might discuss intelligence as a combination of one's abilities to be keenly aware of his present surroundings, to recall readily what he has experienced in the past, and to apply both to the solution of whatever problems may confront him. We must remember that the desire to really use these abilities may be thwarted and warped by prejudice, fear, or other conflicting emotion in even the most intelligent person. However, actual lack or deficiency of these abilities is what we commonly describe as feeblemindedness.

So far we have used this word "feebleminded" quite indiscriminately because it is still in popular use. However, if we are to discuss mental disorders impartially and scientifically we have no use for terms such as "feebleminded" which even to the trained physician brings up associations of pity, of ridicule, and of social stigma. These associations are a relic of the days when we feared what we did not understand in people's behavior and either frankly expressed our fears in all sorts of superstitious notions or else tried to act as though we were not afraid at all, by discussing the behavior of those who were mentally ill or defective as though it were a joke. Now that we are more enlightened we had best use the impersonal terms *mental deficiency* to describe a relative lack of intelligence, and *mental retardation* to describe retarded development of intelligence. For clinical purposes the terms are used almost interchangeably, as the conditions frequently occur together. In dealing with certain types of patient the terms "dull," "slow" or "sluggish" probably describe matters clearly and impersonally. On the contrary avoid the terms

Read before the Providence Medical Association, October 4, 1937.

"idiot," "imbecile" and "moron" which are scientifically accurate classifications but are usually interpreted in a derogatory sense by the layman.

As far as children are concerned, that infant who is born mentally deficient usually develops later at a slower rate than the normal child. If we find him in late infancy only fifty per cent as intelligent as his normal brother, the experience of multitudes of instances tells us that during each subsequent year his intelligence will develop only fifty per cent as rapidly as the average child. It is quite important that physicians and parents understand this clearly, as there is still prevalent a good deal of superstitious belief that at seven years, or at puberty, or at some other such mystic period there may be a sudden acceleration which will restore matters to a normal state. This simply does not occur in the congenitally retarded child. The miracles of which we hear so many and see so few are probably the result of mistaken diagnoses.

Where the intellectual development becomes interrupted by disease or injury of the nervous system, the course is not so predictable. Where the physical illness is continuous, as in chronic encephalitis or uncontrolled grand mal convulsive disorder, we know that intelligence at times becomes progressively more and more retarded. Where the physical insult is acute and temporary, subsequent development may be retarded or may proceed normally leaving only the initial handicap. The variation probably depends on the nature and localization of the pathological lesions. In such instances only periodic observation for some time can determine the prognosis.

Physical Classifications

Physicians would probably feel more at home in the field of mental deficiency if there were a greater coincidence of significant physical findings in this group of children. Until very recently medical training has so emphasized structural physical changes that special experience has been necessary to develop appreciation of alterations which are only physiological or are apparent only in our patients' behavior. The types of mental deficiency which can be classified on a physical basis make up only a very small portion of all the cases which come to our attention. The microcephalic, whose shaven head and top-knot make him the classical defective of the side-show world, and the hydrocephalic, in whom deformity is self evident and the mechanism of brain damage so easily explained, are familiar but infrequent types. The cretin, whose mental defect and subsequent development will respond spectacularly to treatment if thyroid extract is administered continuously from early infancy, is fortunately not common but is conspicuous because here a conventionally administered remedy is available. The mongol, for whom endocrine research is beginning to suggest encouraging but not as yet practical forms of therapy, is generally recognized. In these, as in all types of defective, the degree of retardation varies from case to case as does the personality and disposition, even though there may be some vague similarities in behavior. These clearly recognizable physical types make up a minority of probably not more than ten per cent of all retarded children.

On the other hand the appearance and physical characteristics of the remaining majority are by no means distinctive. Since mental defectives vary in personality just as do their more brilliant fellows, some are placid, some active; some are physically attractive, some plain and uninteresting; some are likable and some aggravating. It is well to remember that the clean, well groomed, neatly dressed, quietly obedient child always presents a far better clinical impression than the unkempt and disarranged urchin who actively pries into every nook and cranny of the office despite the noisy remonstrances and hectic pursuit of his exasperated mother. Yet very dull children may be neatly groomed and obedient, whereas many a brilliant but poorly trained youngster may leave havoc and curses behind him wherever he goes. One must not judge intelligence by appearance and social behavior alone.

Importance of History

For an accurate diagnosis of mental deficiency we rely foremost of all on our clinical history. In the majority of instances it need not be exhaustive but we must have a wide enough assortment of facts to offset the effect of the rosy-hued glasses through which it is only human nature for all parents to view their own children. Developmental details are most important. Useful data include ages of first creeping, walking and talking, and the response to training in toilet habits. It may be quite significant to compare these dates with those observed for other children in the family. In infancy and early childhood, did the patient pay attention to his surroundings, learn rapidly, and profit from

painful experiences? Later in childhood, were his interests comparable with those of other children his own age or was he fumbling with blocks when his younger brother was already driving his velocipede with gestures and vocabulary obviously acquired from the ice-man? Gesell has conveniently tabulated approximate dates for the normal acquisition of various skills early in life, and those of us who deal at all with children are presumably familiar enough with the age limits within which we may expect to see the more common phenomena appear. We may definitely use this knowledge clinically and if the child's early development has been uniformly slow and his present actions and interests immature, he is probably retarded. Moreover, his future development will proceed at about the same relative rate as has been noted in the past. Where, however, the developmental data has been within normal limits, or precocious even in a single respect, we must investigate further.

Two confusing items may appear at this point—namely, that the child's memory for faces and places may appear quite acute, or he may be reported to have an excellent appreciation of music or rhythm. Why these observations should be true in certain very retarted children is not clear, but it cannot be denied. The hereditary history may also be a source of confusion as a gifted child is occasionally seen in a setting of dull parents and relatives whereas solitary defective offspring in intelligent families are fairly common. So, as in all clinical medicine no diagnosis is justified from the history alone.

Clinical Examination

An experienced and skillful clinician can often learn a great deal about a child's intelligence during a brief interview. This involves a good deal more, however, than merely noting responses to a stock set of questions or commands. A very common error is to ask questions of general information, the answers to which a child could only have learned if taught in school or at home and which have very little to do with his actual intellectual capacities. As to observation, it is usually convenient to present a child with some simple object and note what he does with it. There is a vast difference in the information conveyed by a child who merely chews and drools on a tongue depressor and one who examines it and uses it in his play.

One physical sign of severe mental deficiency is worthy of a passing note. Children in this group often show unusual relaxation of their joints. It may be significant if one can easily bend the child's fingers back upon the dorsum of the hand or manipulate the limbs in all sorts of contorted positions with the greatest of ease.

A brief clinical examination may be the only necessary supplement to a careful history in the hands of the experienced physician. On the basis of these he may be able to diagnose accurately the type and degree of retardation, furnish a reliable prognosis, and recommend a desirable plan for training. However, in certain instances he may wish to secure a more precise measurement of his patient's intelligence which may be expressed quantitatively as an intelligence quotient. This being the case, he should request a psychometric examination.

Significance of Intelligence Tests

It must be stated at once that an intelligence test is essentially a laboratory examination, subject to all the limitations of any such procedure. Its reliability is dependent on the skill of the tester and the co-operation of the patient, its most analogous medical counterpart being the conventional test for basal metabolic rate. An assortment of tests are available suitable to various ages and types of patient. Considerable training and adequate experience are necessary before one can reliably select, administer, and report the results of any intelligence test. Most physicians lack this training, cannot afford the time necessary to administer psychometric examinations, and must usually refer such work to a qualified clinical psychologist. Given under satisfactory conditions such tests are remarkably accurate and should no more be neglected in questionable cases of mental retardation than should the proper hematological examination in suspected blood dyscrasia.

With his developmental history and clinical examination supplemented by the laboratory evidence of a psychometric report, any medical man should be in a position to diagnose mental deficiency with reasonable accuracy. The importance to the parent of this diagnosis, with a clear explanation of its significance, is often underestimated. A too gloomy prognosis, perhaps crudely expressed, may result in years of hidden despair and sorrow whereas a vaguely optimistic outlook may result in the squandering of resources for educational aims which can never be achieved. Next to severe physical illness, where life itself hangs in the balance, most parents

are more concerned about the intellectual status of their child than any other aspect of his welfare. The mute evidence of many intelligent parents, wandering from physician to physician with a defective child, seeking a hopeful prognosis or at least a clear explanation of their problem with constructive advice for treatment, again emphasizes the opportunity which has been knocking at the door of the family doctor, who is consulted first of all.

The primary obligations of the family physician are an accurate diagnosis and clear convincing explanation of the nature of the child's defect. He will be able to lift the cloud of hopelessness which surrounds many such patients if he can direct effective training. The actual details of training must be left to the parent or in many instances to experienced educators who have made this field their life work. It is advisable, however, that the physician understand certain fundamentals of this training.

Principles of Treatment

It must be remembered that all but a very few very retarded children will continue to develop in intelligence throughout childhood. This may be at a rate only seventy, fifty, or even thirty per cent of normal and it may cease at an age earlier than is usual. Nevertheless it is quite likely to reach a stage sufficiently advanced to permit some sort of useful activity. As there are many tasks in the world suited to persons of inferior intelligence, some attempt should be made to train the defective child for such an occupation. Just what this position will be must vary with the capacity of the child and the culture into which he has been born. To one it may mean the ability to keep himself clean and neatly groomed so that he may become an acceptable though unobtrusive member of the family group with no need for self-support. To another it may mean training for some routine, physical work with the pick and shovel, washing dishes, or scrubbing floors. The unimaginative, unambitious retarded individual may be quite busy and happy in some of these occupations, which to more intelligent persons seem tedious and uninteresting.

The instruction of the defective child must be based on prolonged, constant, and consistent repetition of each step in training. He learns slowly and only by repeated exposure. There is no short cut. Every new experience is temporarily confusing if forced on his attention. That is why the defective child becomes rapidly and hopelessly lost in the average school where the rate of progress is geared to the superior intelligence of children who grasp things readily and are eager to progress.

Far too much emphasis is commonly placed on the fear that the retarded child will have an unfavorable effect on other children at home or in school. He may be unhappy with them for he is often ridiculed and made the butt of jokes, but superior children never tend to imitate him seriously or in the slightest degree become like him. On the contrary, the dull child usually tries very hard to imitate the actions of those more intelligent. The pains which so many parents take to avoid contact between their own children and a defective child is another relic of the days when we feared what we did not understand.

With these principles in mind, training can often be carried out in the home if parents will cooperate and possess sufficient leisure and energy. Many children, even of very low intelligence, whose dispositions are such that they do not disrupt the home, become extremely well trained and useful at simple tasks. Unfortunately many parents are quite unable to give competent training and many homes are in such a state that there is no place for the child who is not mentally equipped to shift for himself. Also the personalities of a certain proportion of defective children render home training out of the question.

School Facilities

To make up for home deficiencies, some private teachers are available and many public school systems are struggling to provide satisfactory training for some of their dull pupils. Where much of the fundamental drill must be on daily habits of life rather than academic pursuits, it is quite obvious that the intermittent teaching of the day school will not be entirely effective.

As a substitute for home training a residence school has so far supplied the most logical solution. In this country at the present time the choice lies between state-supported institutions and expensive private schools. Unless family finances permit prolonged expenditure of from sixty to two hundred dollars a month for private care, the state school had better be the choice.

The majority of our state schools are capably administered and employ sound methods of training. It is unfortunate that so great a social stigma is still attached to their pupils. It is equally unfortunate that most uninformed visitors to state

schools are more vividly impressed by the untidy and depressing activities of the idiot group, so hopelessly defective as to warrant only custodial care, whereas a far more accurate picture of the real work of the school would be obtained by carefully noting that an attempt is made to fit each child, not in this lowest group, with an occupation suited to his intelligence wherein he is busy, happy, and obtaining training that may eventually prepare him to occupy some humble but useful place in the outside world.

State schools, however, seem usually to be pitifully short of financial support adequate to the best in accommodations and training facilities. Limitation of space makes it necessary for the state school to give preference to the obstreperous defective, who is making a nuisance of himself in the community and whose segregation is therefore urgent. Many other less troublesome retarded children, nevertheless in need of training, cannot be properly accommodated.

There are many excellent private schools for children of sub-normal intelligence but they are expensive. Experienced personnel and special equipment adequate for the intensive training of every pupil cannot be purchased cheaply. Parents should be wary of schools where commercialism has intruded in the form of too enthusiastic advertising claims, showy but unnecessary equipment, or financial rates incompatible with high educational standards. The physician probably would do well to visit personally one or two good private schools for retarded children as he will not only find the visit interesting and instructive but will thereafter be in a much better position to discuss the placement of his patients.

The obligations of the family physician to his retarded patient are fulfilled if he can instruct the parent in the necessary training or else see that the child is placed in the proper school. If he has diagnosed correctly and explained his diagnosis clearly, without prejudice or uncertainty, he has dealt with mental deficiency in the same practical way in which he handles other medical matters. If, in addition, he is equipped to recommend a definite course of treatment or training, he has demonstrated that he is abreast of the times and knows that there is actually a great deal to be done for that frequently neglected individual—the mentally defective child.

PERIPHERAL ARTERIAL DISEASE

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Some Practical Considerations

It was over one hundred years ago that the first important step was made in the classification of peripheral arterial disease. This event was the discovery in 1835 by Cruveilhier[1] that senile gangrene is caused by the closure and thrombosis of the arteries of the extremities. In 1855 Charcot[2] coined the term "intermittent claudication", which he correctly inferred was caused by ischemia of the muscles and nerves as a result of impaired arterial supply. Raynaud[3] in 1860 segregated cases of "local asphyxia and symmetrical gangrene", which he properly attributed to spasm of the capillary vessels. With surprising insight he was able to predict the influence of the sympathetic nervous system in producing the vasospasm. More recent was Buerger's description[4, 5] in 1908 of thrombo-angiitis obliterans as a clinical and pathological entity. Arteriosclerosis, Raynaud's disease, and thrombo-angiitis obliterans constitute the great majority of cases of chronic occlusion of the peripheral arteries.

The detection of impaired circulation is relatively easy when the pathology is advanced, particularly in the presence of definite gangrene and excruciating pain. It is important, however, to be thinking of these conditions at all times in order to discover the cases early, when treatment is most likely to be of benefit.

Arteriosclerosis and Buerger's disease can conveniently be discussed together. The most striking symptom in the history of both conditions is pain. Intermittent claudication is almost pathognomonic of faulty circulation but rest pain is not uncommon, particularly in the more advanced cases.

A story of cramp-like sensations in the calf or in the foot induced by walking, and disappearing on rest, is often a relatively early symptom. Various kinds of paresthesias may also occur and are, incidentally, quite resistant to treatment.

The age of the patient is important in differentiating the two diseases. Buerger's disease characteristically starts at an early age and is usually well

Read before the Providence Medical Association, October 4, 1937.

established before the fortieth year. Arteriosclerosis, on the other hand, is a disease of elderly people, not common before fifty. Buerger's disease is almost entirely limited to males, although the disease is said to have occurred rarely in females. Arteriosclerosis, on the contrary, may occur in either sex. It was formerly supposed that Buerger's disease was limited to the Jewish race but this false impression is now completely dispelled. The use of tobacco in patients with Buerger's disease is an almost constant finding. In over 1,000 instances Silbert[6] did not find a single typical case in a non-smoker. Occasionally, however, such cases are reported in the literature. Another characteristic finding in thrombo-angiitis obliterans is migrating phlebitis; the association of thrombosis of the superficial veins of the upper and lower extremities with obliteration of the larger arteries occurs often enough to make the thrombophlebitis almost pathognomonic. It is usually important to make a differential diagnosis between Buerger's disease and arteriosclerosis because of the difference in prognosis and the effect this may have on the surgical evaluation and treatment. This differentiation is usually most difficult in patients between the ages of forty and fifty. Silbert[6] has listed a number of points which should aid in the diagnosis. Patients with Buerger's disease often appear younger than they actually are, while those with arteriosclerosis appear older. In the first group the hair is normally pigmented, while in the latter it is usually gray. The presence of arcus senilis points to arteriosclerosis. Examination of the retinal arteries with the ophthalmoscope will reveal the presence of sclerosis.

An elevated blood pressure likewise points to arteriosclerosis. Thickening of the radial and temporal arteries is usually not found in Buerger's disease. Involvement of the upper extremity, however, while frequent in thrombo-angiitis obliterans, is unusual in arteriosclerosis. Closure of the femoral artery is frequent in Buerger's disease but seldom seen in arteriosclerosis. The X-Ray may be useful in showing sclerotic calcification of the peripheral arteries or arteriosclerosis of the aorta. Kidney impairment and symptoms of coronary artery disease both point to arteriosclerosis. In other words, evidence of generalized arteriosclerosis points to this disease in the extremity. Finally a history of migrating phlebitis indicates Buerger's disease.

Both extremities should always be examined together. Characteristic changes will usually be found. Variations in color are very common and can be demonstrated by examining the feet in different positions. Elevation will produce a characteristic cadaveric pallor and the resulting ischemia often causes the patient appreciable discomfort. Following this the extremity should be placed in the dependent position. It will then turn to a bright red hue with varying degrees of cyanosis, a striking color change known as rubor. The skin may become dry and smooth and the nails thickened. There is usually an absence or sparcity of hair. Trophic ulcerations occur characteristically about the toes and nails, especially of the great toe. These may be very painful.

Significant changes in the temperature of an extremity can usually be discovered by ordinary palpation. A convenient skin thermocouple is now available, however, which permits skin temperature determination with considerable accuracy. This is useful chiefly in the measurement of peripheral vasospasm. Temperature readings before and after nerve block with novacaine indicate the amount of vasospasm present.

Examination of the extremity for the presence of pulsations should always be made. The femoral, popliteal and posterior tibial arteries should all be tested but most important of all is the dorsalis pedis. The presence of a dorsalis pedis pulsation practically rules out arterial impairment of any clinical importance.

In the more doubtful cases an oscillometer may be used to demonstrate the degree of pulsation. An ordinary blood pressure cuff makes an excellent oscillometer for practical purposes. After partial inflation of the cuff the pulsation will be reflected in the movements of the needle or mercury column. The importance of palpating the dorsalis pedis artery in every examination of the extremity cannot be overemphasized. The presence of pain and paresthesias in both neurological and circulatory conditions may be confusing. Arterial disease is not uncommonly mistaken for flatfoot; it is frequently overlooked as the primary cause for infections about the lower extremity. Furthermore, a urine examination should always be done, to rule out diabetes.

The basic treatment in these conditions is quite simple but meticulous attention to detail must be observed. The primary elements are (1) hygiene,

(2) Buerger's exercises, and (3) complete cessation of smoking. The feet should be kept scrupulously clean; gentle cleansing with soap and water followed by the application of lanolin will suffice. Small pieces of lamb's wool between the toes may prevent trauma. Buerger's exercises should be done three or four times daily. These exercises consist basically in closely supervised and accurately timed periods of ischemia alternating with periods of passive congestion and rest. The timing should be worked out individually for each patient depending on the length of time required for blanching and the comfort of the patient.

It is almost universally accepted now that tobacco is harmful in peripheral arterial disease. There will usually be some benefit from partially restricting its use but to obtain the maximum effect it is essential to withdraw it completely. Silbert[6] is convinced that in thrombo-angiitis obliterans the progress of the disease stops with the cessation of smoking.

The basic treatment as outlined will usually suffice in the uncomplicated cases. In the presence of complications such as gangrene, infection and pain, further procedures may become necessary. As a general rule conservative measures will be far more successful in Buerger's disease than in arteriosclerosis. Extensive infection and gangrene, requiring a major amputation in arteriosclerosis, will often yield surprisingly to local treatment, incision and drainage, and minor amputations. Crusts should always be removed because of the frequency with which they conceal infection. The infection itself is best treated with ordinary bland wet dressings such as saline or boric acid solution.

The next most important consideration is the treatment of pain. When ordinary sedatives and analgesics are not sufficient, it becomes necessary to interrupt the sensory supply of the foot. Perhaps the best operation available for this purpose is that of nerve-crushing as developed by Smithwick and White[7]. It is possible to completely denervate the involved area and thus give the patient genuine comfort and allow time for local healing. The sensory innervation of the foot is carried in five trunks; the superficial and deep peroneal nerves, and the posterior tibial, sural and saphenous nerves. It is generally advisable to crush all of them.

The sensory nerves carry, in addition to the sensory components, the vasoconstrictor sympathetic fibers. The denervated area is therefore sympathectomized as well as desensitized. Since a considerable number of these patients have some vasospasm, this additional effect is important in promoting healing. It should rarely be necessary, at least in Buerger's disease, to do a major amputation for pain alone.

In addition to these measures Silbert[6] has been using for a number of years intravenous injections of 5 per cent sodium chloride in the treatment of thrombo-angiitis obliterans.

Because of his extensive experience his judgment must be given serious consideration. Up to 1935 he had used this procedure in 524 cases in addition, of course, to the other measures already outlined. In this entire group only 7.6 percent eventually required amputation of an extremity. In view of the excellent general care that his patients receive, however, most workers remain skeptical about the value of this particular measure.

Intravenous typhoid vaccine has a somewhat limited use in those patients who have vasospasm. The vasodilator effect is transient but may be useful in those cases not advanced enough to warrant nerve crushing or lumbar sympathectomy.

A recent innovation that has attracted considerable attention is passive vascular exercise[8, 9]. This consists in subjecting an extremity to alternating positive and negative pressures by means of a specially designed glass boot. Such an apparatus has been accepted by the Council on Physical Therapy but its use seems to be contraindicated in advanced cases of thrombo-angiitis obliterans and arteriosclerosis. Another mechanism recently introduced is intermittent venous compression[11, 12], produced by a cuff resembling a blood pressure cuff with some suitable attachment to vary the compression. Both types of apparatus apparently accomplish their effect by causing an intermittent hyperemia. There is as yet no clear-cut evidence that they are superior in chronic obliterative disease to Buerger's exercises carefully performed. They are certainly not indispensable.

The final clinical entity to be considered is Raynaud's disease. A thorough treatment of this subject is not practicable in the present discussion. A few facts regarding treatment, however, may be emphasized. Use of warm clothing, such as woolen gloves and woolen socks, may help to arrest the symptoms. When possible, removal to a warm climate can be recommended. In the more severe

cases, however, it is necessary to resort to sympathectomy.

Disease of the lower extremities has been successfully treated by lumbar sympathectomy for a number of years past. It is only recently that it has been possible to promise relief to patients in whom the upper extremities are affected. Smithwick and White[13] have demonstrated that the preganglionic rather than the postganglionic sympathetic fibers must be removed. An operation which accomplishes this result[14] in the upper extremity, namely preganglionic dorsal sympathectomy, has now been devised, and has been used successfully.

Summary and Conclusion

The differential diagnosis of arteriosclerosis of the extremity and thrombo-angiitis obliterans is presented. The basic treatment for both conditions is discussed; it is comprised of the following measures: (1) hygiene. (2) Buerger's exercises, and (3) withdrawal of tobacco. Complications such as infection, gangrene and pain necessitate further procedures. Particular emphasis is given to the operation of nerve-crushing, which is effective not only in relieving pain, but also in producing vasodilatation. Major amputation should be much less frequent in Buerger's disease than in arteriosclerosis.

The surgical treatment of Raynaud's disease is successful now in the upper as well as the lower extremity. This has been made possible by the introduction of preganglionic dorsal sympathectomy.

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ADVERTISING

Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings, and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards. It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

From the Code of Ethics of the A. M. A.



THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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FEDERAL CONTROL OF HOSPITALS

Senator J. Hamilton Lewis at a meeting of the representatives of the American Medical Association said, in effect, "whether you like it or not you must be prepared for some form of regulated medicine."

He intimated that the control would be from the federal government. How that would operate is illustrated in cities where there are naval training stations. In these locations, a naval doctor is delegated by the naval authorities to take care of the civilian dependents of the enlisted men.

In a city of 30,000 people it has been found that the average attendance at the dispensary of the naval hospital from this civilian population was twenty-three a day; the house calls from ten to twelve a day. In addition to this, operations requiring hospitalization would average two to three a week. It can be readily understood when services of this kind are furnished, the income of the local physician is markedly affected.

Specifically, if one-half the dispensary cases paid, and that is a fair average, it would amount to about seven thousand dollars a year; one-half of the house cases would mean an income to the doctor of about ten thousand dollars. It is difficult to apply any average to operations but it can be estimated not less than five thousand dollars a year so that it would aggregate close to twenty-five thousand dollars a year. This amount is taken out of the income of the civilian practitioner.

It is true that this is a service to the enlisted personnel, but if the same services are given to the citizens at large the income of the local doctor will be diminished.

What is to be done? Unless the physicians as a whole give this question serious consideration, and adopt a method agreeable to all, it is believed the government will step in and make plans whether the doctor likes it or not.

TEACHING SEX HYGIENE IN PUBLIC SCHOOLS

It's pathetic to see youngsters skipping about, playing with beer, wines and cocktails and exposing themselves to all sorts of sexual dangers. They think that they know a lot. Compared with our grandparents perhaps they know a great deal, but when you analyze their knowledge you see that they know very little. Physicians are confronted with the pathetic situations created by a lack of this knowledge. Why shouldn't children be taught something about sex hygiene in school? You can't get by with letting youngsters read pamphlets which are worded in beautiful and obscure language. They want the facts before them and in as few words as possible. How many more years will we continue our stupid, prudish attitudes towards these matters? How much longer will we allow religious organizations to dictate on such matters? After all, it is not a pleasant subject to teach but it can be done by the right person. Just as girls are training themselves to take care of speech defects in school children, why not train special teachers who would take care of sex teaching on a scientific basis? A modern civilization demands such a course. But perhaps we're not as civilized as we think we are.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the November Meeting

The regular meeting of the Providence Medical Association was held at the Medical Library on November 1, 1937, and was called to order by the President, Dr. Peter Pineo Chase, at 8:30 P. M. The Secretary read the minutes of the October meeting which were approved as read. The Secretary read a letter from Dr. Francis V. Corrigan, Chief of the Bureau of Child Health of the Rhode Island State Department of Public Health, outlining a plan for providing free consultation service for pediatric and maternity cases among the indigent of the State. The matter was discussed by Dr. Corrigan.

The application for membership of Alfred Clement Conte having been approved by the Standing Committee, on motion of Dr. Mowry, Dr. Conte was elected to membership by a ballot cast by the Secretary.

The report of the Committee on Reorganization, presented at the October meeting, was read by the Secretary as approved by the Standing Committee. On motion by Dr. Ruggles, after discussion by Dr. William S. Streker, the report was adopted by unanimous vote of the meeting. Dr. Ruggles then spoke in behalf of the Providence Community Fund.

Dr. Ernest M. Daland, Surgeon-in-chief at the Pondville Hospital at Pondville, Massachusetts, then addressed the meeting on "Treated versus Untreated Cancer." He offered statistical proof of the benefit of treatment for cancer of the breast and rectum. The address was illustrated by lantern slides. It was discussed by Drs. Kingman, Chase and Daland.

Dr. Richard H. Miller, Professor of Surgery at Harvard Medical School, read a paper on "Ulcer and Cancer of the Stomach and Ulcer of the Duodenum." The paper was illustrated with lantern slides. It was discussed by Dr. Ralph W. Franch of Fall River, Massachusetts, and by Drs. Bray, W. S. Streker, Morein and Miller.

The meeting was adjourned at 10:30 P. M. Attendance, 200. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D.,
Secretary

PAWTUCKET MEDICAL ASSOCIATION

Minutes of the October Meeting

The regular meeting of the Pawtucket Medical Association was held at Memorial Hospital on October 21, 1937. The Vice President, Dr. Charles L. Farrell, presided. Communications were presented from the Community Chest, Inc., from the Chief of the Bureau of Child Hygiene, and from Dr. Herman B. Marks. The application of Dr. A. F. Melluci for regular membership was presented. Dr. Robert T. Henry reported for the Committee on By-laws. It was voted that the dues remain the same as for the preceding year.

Dr. J. L. Turner gave a "Résumé of Work Done by the Obstetrical Department at Memorial Hospital."

The Acting President appointed Dr. Earl F. Kelly, Chairman, and Drs. B. L. Towle and Stephen A. Kenney, as members of a Committee to study the reasons why members do not attend the meetings.

The meeting was adjourned at 10:30 P. M. Collation was served.

Respectfully submitted,

THAD. A. KROLICKI, M.D.,
Secretary

Minutes of the November Meeting

The regular meeting of the Pawtucket Medical Association was held at the Nurses' Auditorium of the Memorial Hospital on November 18, 1937. The meeting was called to order by the Vice President, Dr. Charles L. Farrell. It was unanimously voted that Dr. George J. Howe be exempt from payment of dues in accordance with the by-laws. An application for regular membership from Dr. Upton A. Savoie was ordered to pass through the regular channels. Action on the applications of Dr. Herman Marks, Dr. R. Lussier and Dr. A. Melluci was deferred to a later date and referred back to the Standing Committee for reconsideration.

Numerous communications from members who were unable to attend the meeting were read, each and every one expressing strong opposition to State Medicine. The President was directed to consult with Dr. Elliott M. Clarke on matters under consideration. The Secretary was instructed to write to the secretaries of the Rhode Island State Society and of each District Society of the unanimous vote of the Pawtucket Medical Association, on record as opposed to State Medicine.

Dr. Herbert E. Harris then gave an illustrated talk of "Hip Conditions in Children" at the conclusion of which he was given a rising vote of thanks.

Dr. Charles L. Farrell showed a movie film demonstrating the injection method of treatment for hernia. The meeting was then adjourned. Attendance, 36, the largest in five years at a regular meeting. Collation was served by the Dietetic Department of the Memorial Hospital.

Respectfully submitted,

THAD. A. KROLICKI, M.D.,
Secretary

MEMORABILIA

November 7. The first of the Sunday Public Lectures, held at the Medical Library under the direction of the Committee on Education of the Rhode Island Medical Society, was given by Dr. Alex. M. Burgess, with the subject "Colds, Grippe and Pneumonia." Dr. George L. Young presided and introduced the speaker. Attendance, 132.

November 12. Dr. Francis B. Sargent entertained the William W. Keen Medical Club. Dr. Guy W. Wells conducted a round table discussion on "Carbon Tetrachloride Poisoning" which was participated in by Drs. B. Earl Clarke, John C. Ham and Dr. Paul Reznikof, Assistant Professor of Medicine at Cornell Medical School.

November 14. Dr. Charles P. Fitzpatrick, Clinical Director at Butler Hospital, giving the Sunday Public Lecture at the Medical Library, spoke on the subject, "What Can be Done About Mental Disease?" He outlined the benefit which often results from change in environment and described treatment by insulin shock, convulsion therapy with metrazol, fever therapy in neurosyphilis. Dr. Thad. A. Krolicki introduced the speaker. Attendance, 172.

November 15. At the regular meeting of the Thirty-four Medical Club, Dr. Robert R. Baldridge presented a paper on "Tumors of the Cecum."

November 16. Dr. Charles H. Lawrence addressed the meeting of the General Staff of the Homeopathic Hospital of Rhode Island. His subject was "Endocrinology and its Relation to General Practice." Luncheon was served at the close of the meeting.

November 18. The regular monthly meeting of the Staff Association of St. Joseph's Hospital was held at 12:00 o'clock noon in the Nurses' Auditorium. Dr. William A. Horan spoke on "Some Pathological Changes in the Bones and Joints of the Lower Extremities." A collation was served.

November 19. At the meeting of the Friday Night Medical Club, Dr. Albert H. Miller spoke on "Why Keep Records?" He presented the opinion that in medicine as elsewhere there can be only one best way to do anything.

November 21. Dr. Joseph L. Dowling gave the third Sunday Public Lecture at the Medical Library. His subject was "Common Causes of Blindness." Dr. Jesse P. Eddy, 3rd, presided. Attendance, 215.

November 23. The Amos Throop Medical Club was entertained by Dr. Arthur T. Jones. Dr. Eliot A. Shaw reported the recent meeting of the Interstate Postgraduate Medical Association of North America which he attended at St. Louis on October 18-22.

Memorial Hospital

INTERNE ALUMNI CLINIC DAY

The fifth annual Interne Alumni Clinic Day was held at the Memorial Hospital on November 3. Three hundred and seventy-five physicians and surgeons registered for the morning and afternoon sessions. The guests were presented pamphlets on "Instruction in the Care of Diabetic Patients, for the Medical Service." "Instruction for Nurses in the Care of Diabetic Patients." "Instruction for Diabetic Patients."

At the morning session the following demonstrations were given by members of the staff:

Under the direction of Dr. Francis B. Sargent, Chief of the Ear, Nose and Throat Division. *Oto-Laryngology in Diabetes* — Presentation of Cases, by Drs. Francis B. Sargent and Gordon J. McCurdy.

Under the direction of Dr. John G. Walsh, Chief of the Obstetrical Division: *Pregnancy Complicated by Diabetes,* by Dr. Alfred L. Potter. *Treatment of Acne Vulgaris by Insulin,* by Dr. William B. Cohen.

Under the direction of Dr. J. Edwards Kerney, Chief of the Urological Division: *Infections of the Upper Urinary Tract in Diabetes Mellitus,* by Dr. J. Edwards Kerney. *Cord Bladder in Diabetes,* by Dr. Stanley Sprague.

Under the direction of Dr. Raymond F. Hacking,

Chief of the Eye Division. *Eye Complications in Diabetes,* by Dr. Raymond F. Hacking.

Under the direction of Dr. John F. Kenney, Chief of the Medical Division: *Comments on and Summary of Our Experience with Protamine Zinc Insulin,* with illustration of cases, by Drs. Jacob Greenstein and Francis E. Hanley.

Under the direction of Dr. Earl F. Kelly, Chief of the Pediatric Division: *Practical Demonstration. Presentation of Cases. Methods of Control in Diabetic Children,* by Drs. Reuben C. Bates and Earl R. White.

Under the direction of Dr. Frederic V. Hussey, Chief of the Surgical Division. *Surgery in Diabetes,* by Dr. Frederic V. Hussey.

Under the direction of Dr. Roland Hammond, Chief of the Orthopedic Division: *Blood Sugar Determinations on Orthopedic Cases* — report of 30 cases, by Dr. John H. Gordon.

At 1 P. M., a buffet luncheon was served.

Dr. John F. Kenney presided at the afternoon session, held in the Auditorium of the Nurses' Home. The following program was presented by a group of Professors of Yale University School of Medicine:

Individualized Treatment of Diabetes, Dr. John P. Peters, Professsor of Medicine.

Extra-Pancreatic Diabetes, Dr. C. N. H. Long, Professsor of Physiological Chemistry.

The Use and Abuse of Insulin, Dr. Paul H. Lavietes, Assistant Professor of Medicine.

Surgery in the Diabetic, Dr. Ashley W. Oughterson, Associate Professor of Surgery.

The evening session was held at the Providence Biltmore Hotel. The President, Dr. J. Lincoln Turner, introduced Dr. John F. Kenney as toastmaster.

He in turn introduced Mr. Herbert M. Sherwood, who spoke about the "Future of the Government." He was followed by Col. H. Anthony Dyer, who spoke on the "Future of the Government" in contrast to the previous speaker. He also carried the gathering through many parts of Italy and some other countries. Dr. Frederic V. Hussey closed the evening program with remarks in praise of both speakers, together with praise for the work the Memorial Hospital Staff is doing.

These clinics are becoming more and more largely attended each year not only by our Rhode Island men but by men from all Southern New England as well.

A Clinical Conference was held by the Staff and Associate Members at the Memorial Hospital on October 13, 1937. A symposium on thyroid disease was carried out by Dr. John F. Kenney, Chief of the Medical Service; Dr. Frederic V. Hussey, Chief of Surgical Service; Dr. Emanuel W. Benjamin, in charge of the X-ray Department; Dr. Meyer Saklad, in charge of the Anesthesia Department; and Dr. John H. O'Brien, of the Thyroid Service. After presentation, the various staff members discussed the different points brought out by the speakers. This is a second of a series of symposia which are being conducted at the hospital by the staff.

Dr. S. Willard Bridgham has opened an office for the practice of medicine and surgery at 152 East 94th Street, New York City.

Rhode Island Hospital

Dr. Howard R. Ives of Portland, Me., Williams University and Yale Medical School, started a two years' internship at the Rhode Island Hospital on November 15th. Previous to coming to the Rhode Island Hospital, Dr. Ives interned at Notre Dame Bay Memorial Hospital at Twillingate, Newfoundland, for a period of 4 months. This institution is operated on a co-operative medical basis by which the Newfoundland Government pays half hospital expenses and the people supply the other half. It costs the individual only 44 cents per year for hospital care and medical treatment.

On November 1st, Dr. Stephen Harris started a three months' internship at the Charles V. Chapin Hospital.

On October 31st, at the Lying-In Hospital, to Dr. and Mrs. Frank Bryant Cutts, a son, William Bryant Cutts, 2nd.

Woonsocket Hospital

At the regular meeting of the Woonsocket Hospital Staff on October 11, 1937, Dr. Victor H. Monti read a paper on "Postoperative Care." The discussion which followed was opened by Dr. Francis J. King, and continued by Drs. W. C. Rocheleau and E. D. Clarke.

The monthly Clinical Conference was held October 25, 1937. Dr. H. Lorenzo Emidy presented a case of "Lateral Sinus Thrombosis complicated by Pneumonia."

Dr. Leo V. Conlon presented a case of "Extensive Burns" showing remarkable results obtained by treating with silver nitrate and tannic acid.

The Woonsocket Chapter of the Benevolent Order of Elks recently presented the Hospital with a combination respirator and incubator. Would that more organizations feel the same charitable urge and encourage such noble acts.

Newport Hospital

A meeting of the Newport Hospital Medical Staff was held Tuesday, October 19, 1937. Dr. Douglas P. A. Jacoby presided. The meeting was given up to the consideration of group hospitalization. The details were explained by Mr. John Mays, superintendent of the Abington Hospital, Abington, Pa.

He pointed out particularly that this method of hospital work ought not to be tried unless the members of the staff endorsed it and willingly co-operated. Where it has been established in communities the size of Newport, he says, it has succeeded.

He believes a membership of four thousand could be developed here, and on the payment of seven dollars a year a member can be given the privilege of the hospital for twenty-one days in a year and if further hospitalization was necessary a contribution in the way of part payment would be made. The members would be placed in semi-private rooms.

Since very few people make plans for the oncoming of sickness, this method of paying hospital bills, he said, was successful; the theory being that since the hospital expenses were taken care of the insured could plan to pay the doctor's fee. No action was taken but doubtless the staff will consider the question at a later meeting.

Minutes of the Caduceus Club

The monthly meeting of the Caduceus Club was held at the Nurses' Auditorium, Memorial Hospital, November 8, 1937. The meeting was called to order by the President, Dr. Earl J. Mara. Dr. Charles L. Farrell, Chairman of the Publicity Committee, reported the successful inauguration of the Diphtheria Immunization Campaign and the Medical Lecture Series.

A complete report of the "Insurgent Physicians" petition, as recorded in a current issue of the *New York Times,* was read by Dr. Joseph Doll. There was considerable discussion concerning this document, at the completion of which Dr. Charles L. Farrell motioned that a committee be appointed to investigate this Article and to draw up a set of Resolutions for or against the proposals contained therein. This motion was seconded by Dr. J. Lincoln Turner and carried unanimously. President Mara immmediately appointed the following committee: Dr. Charles L. Farrell, Chairman, Dr. Orland F. Smith, Dr. Stanley Sprague, Dr. J. Lincoln Turner, and Dr. John F. Kenney.

On November 12, a special meeting of the Caduceus Club was called by President Mara. The Resolutions of the Special Committee were read by the Chairman, Dr. Charles L. Farrell, Dr. James L. Wheaton motioned that the Resolutions be accepted in their entirety, and that copies of the Resolutions be sent to every physician in Rhode Island, to every Medical Society in the State, to the editor of the Journal of the American Medical Association, and to the press. This motion was seconded by Dr. Turner and carried unanimously.

Enclosed is a copy of the Resolutions.

Respectfully submitted,

GEORGE B. MCCLELLAN, M.D.,
Secretary

Resolutions of the Caduceus Club

WHEREAS: The attempts of a small specialized class of physicians non-representative of general medical practice to control and direct medical policies and care have been rebuffed by the rank and file of the medical profession, and

WHEREAS: Their further attempts to indorse state medicine by openly sponsoring a program which has been overwhelmingly rejected by the duly accredited representatives of one hundred thousand physicians—be it

RESOLVED: That we, The Caduceus Club of Pawtucket, R. I., composed of local physicians of general practice, do denounce such a group as "special privilege seeking" and indifferent to the welfare of either the profession or the great mass of people whom it serves, and

BE IT FURTHER RESOLVED: That we will unceasingly bend every effort to offset the harm to the profession and the public that their unwise and precipitate action has caused by calling on all medical societies in Rhode Island to plan co-operative action in enlightening the general public in regard to the menace of state medicine and in furtherance

of which we append our refutation of the principles and proposals advanced by the group of four hundred and thirty doctors who appear to advocate drastic changes in medical care.

The principles and proposals cited by four hundred and thirty medical men and presented to the medical organization for consideration are:

PRINCIPLES

"1. That the health of the people is a direct concern of the government."

In answer to which we maintain that the responsibility of the state is limited to the medical care of the frankly and honestly indigent and those whose health is a menace to the welfare and safety of the community.

"2. That a national public health policy directed toward all groups of the population should be formulated."

This principle is vague, non-specific and indefinite; the application of which would be abhorrent to a great mass of citizens.

"3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches to their solution."

We subscribe to the principle but emphasize that its solution is local not national in scope.

"4. That in the provision of adequate medical care for the population four agencies are concerned; voluntary agencies, local, State and Federal government."

This statement is in accord with existing conditions.

PROPOSALS

"1. That the first necessary step toward the realization of the above principles is to minimize the risk of illness by prevention."

We subscribe to the proposal and are now actively engaged in such endeavor.

"2. That an immediate problem is provision of adequate medical care for the medically indigent, the cost to be met from public funds (local and/or State and/or Federal)."

There is no immediate problem for provision of adequate medical care for the indigent in Rhode Island and evidence tends to prove that *available* medical care is not used to its fullest extent.

"3. That public funds should be made available for the support of medical education and for studies, investigations and procedures for raising the standards of medical practice. If this is not provided for, the provision of adequate medical care may prove impossible."

Public funds means bureaucratic control with its attendant evils to all of which we are strongly opposed.

"4. That public funds should be available for medical research as essential for high standards of practice in both preventive and curative medicine."

We subscribe to this proposal and point out that such procedures are already in operation.

"5. That public funds should be made available to hospitals that render service to the medically indigent and for laboratory and diagnostic and consultative services."

The principle of this proposal is approved but because of a lack of a specific plan, it cannot be subscribed to at present.

"6. That in allocation of public funds existing private institutions should be utilized to the largest possible extent and that they may receive support so long as their service is in consonance with the above principles."

The allocation of public funds brings about political control and until specific and well controlled plans are evolved, it is premature to approve this proposal.

"7. That public health services, Federal, State and local, should be extended by evolutionary process."

Proper co-operation of existing public health services with practicing physicians render further extension of government services unnecessary.

"8. That the investigation and planning of measures proposed and their ultimate direction should be assigned to experts."

Any investigation of the measures proposed should be by a group of expert and truly representative medical men who are best qualified to know what their patients and their practice need and not by professional philanthropists and sociologists whose first consideration is the furtherment of their own financial aggrandizement.

"9. That the adequate administration and supervision of the health functions of the government, as implied in the above proposals, necessitates, in our opinion, a functional consolidation of all Federal health and medical activities, preferably under a separate department."

Such a proposal would be costly, political in character, and increase bureaucratic control.



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SCHEDULE FOR DECEMBER, 1937

Thursday, December 2:	
Gyn. Staff Meeting	8:30 P. M.
Friday, December 3:	
G. U. Staff Meeting	7:30 P. M.
Surgical Staff Meeting	8:30 P. M.
Tuesday, December 14:	
Clinical-Pathologic Conference	12:00 noon
Mondays:	
Surgical Grand Rounds	10:00 A. M.
I. December 6, 20	
II. December 13, 27	
Thoracic Clinic	4:30 P. M.
Tuesdays:	
Gastro-Intestinal Clinic	9:30 A. M.
Surgical Grand Rounds	10:00 A. M.
I. December 14, 28	
II. December 7, 21	
Wednesdays:	
Tumor Clinic	10:00 A. M.
Skin Clinic	12:00 noon
Thursdays:	
Orthopedic Grand Rounds	9:00 A. M.
Thoracic Clinic	11:30 A. M.
Fridays:	
Fracture Grand Rounds	11:00 A. M.
Pediatric Grand Rounds	11:00 A. M.
December 3, 17, 31	
Heart Conference	11:30 A. M.
Saturdays:	
Neurological Grand Rounds	9:00 A. M.
Medical Conference	10:00 A. M.
December 25	Christmas Day

American Medical Association Meeting San Francisco, June 13th-17th, 1938

The San Francisco Session promises to be an outstanding one by reason of the scientific program, scientific and technical exhibits and social functions. In addition, there is the lure of California with its scenic beauty, majestic mountains, fertile valleys and historical background. An opportunity presents to combine profit of the program with the pleasure of visiting San Francisco, the Golden Gate City with the two bridges, engineering wonders of the world.

Requests for hotel reservations may be sent to the Hotel and Housing Committee, 450 Sutter Street, San Francisco, California.

A "Golfers' Special" to the San Francisco meeting of the A. M. A. is being organized by the American Medical Golfing Association. Physicians who like golf mixed with their travel will find five games arranged on the trip out to the coast for the A. M. A. meeting of June 13, 14, 15, 16 and 17, 1938, and three games on the return trip through the Northwest. The first game will be played in New Orleans, reached by the Steamship Dixie from New York or via a rail itinerary, on Tuesday, June 7, 1938. Other stops include Houston, Galveston and San Antonio, Texas; Los Angeles and Del Monte, California; and finally San Francisco where the big A. M. G. A. tourney will be held on Monday, June 13, 1938. The return trip includes Portland, Oregon; Seattle, Washington; Vancouver, B. C.; Lake Louise and Banff, and finally St. Paul and Chicago. Non-golfers as well as golfers, and their ladies, are welcome and will find the A. M. G. A. Special a glorious experience. For full particulars write Dr. Walt P. Conaway, President of the A. M. G. A., 1723 Pacific Avenue, Atlantic City, N. J.; or Bill Burns, Executive Secretary, 2020 Olds Tower, Lansing, Michigan.

Two vocational pamphlets, "Nursing and How to Prepare for It" and "Nursing—A Profession for the College Graduate," are available to physicians, who in addition to their many other responsibilities must often act as vocational advisors and confidants to their young patients. These two pamphlets, which slip easily into any inside coat pocket, suggest answers to such questions as "Will I make a good nurse?"; "Is there a future in nursing for me?"; "What nursing schools shall I enter?". They outline the general admission requirements of nursing schools, provide criteria for choosing a nursing school, and discuss briefly the opportunities within the nursing profession.

The pamphlets have been prepared by the Nursing Information Bureau of the American Nurses' Association, which co-operates closely with the National League of Nursing Education and the National Organization for Public Health Nursing. Physicians who wish to have copies of them either for reference or to give to some of their interested young patients, may secure them, free of charge, from the Executive Secretary of the Rhode Island State Nurses' Association, 381 Angell Street, Providence.

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